

Vanderbilt Assessment Follow up – Parent Informant

Date: _____ Child's Name: _____ DOB: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors in the past _____ when rating his/her behaviors.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
2. Has difficulty playing or beginning quiet play activities	0	1	2	3
3. Fidgets with hands or feet or squirms in seat	0	1	2	3
4. Leaves seat when remaining seated is expected	0	1	2	3
5. Runs about or climbs too much when remaining seated is expected	0	1	2	3
6. Talks too much	0	1	2	3
7. Blurts out answers before questions have been completed	0	1	2	3
8. Has difficulty waiting his or her turn	0	1	2	3
9. Interrupts or intrudes on others' conversations and/or activities	0	1	2	3
10. Avoids, dislikes or does not want to start tasks that require ongoing mental effort	0	1	2	3
11. Has difficulty organizing tasks and activities	0	1	2	3
12. Has difficulty keeping attention to what needs to be done	0	1	2	3
13. Does not seem to listen when spoken to directly	0	1	2	3
14. Is easily distracted by noises or other stimuli	0	1	2	3
15. Is forgetful in daily activities	0	1	2	3
16. Loses things necessary for tasks or activities (toys, pencils, assignments or books)	0	1	2	3
17. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
18. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (teams)	1	2	3	4	5



Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite – explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon or evening – explain below				
Socially withdrawn – decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking – explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing – explain below				
Sees or hear things that aren't there				

Explain/Comments:

<p>For Office Use Only</p> <p>Total Symptom Score for questions 1-18: _____</p> <p>Average Performance Score for questions 19-26: _____</p>
--

- 589 Okeechobee Blvd. Suite 102 West Palm Beach, FL 33417 (561) 471-1144
- 12955 Palms West Dr. Suite 100, Loxahatchee, FL 33470 (561) 798-2468
- 8200 S. Jog Rd. Suite 101, Boynton Beach, FL 33472 (561) 509-5009