	***TLC Pediatrics Revere*** ***280 Beach St*** ***Revere, MA 02151*** ***(P)781-289-5057*** ***(F) 781-289-4485***	***TLC Pediatrics Everett*** ***391 Broadway Suite 301*** ***Everett, MA 02149*** ***(P) 617-389-2121*** ***(F) 617-389-4194***

~ Janet Chua, M.D. ~ Leonard Firer, M.D. ~

~ Analisa Echeverria, C.P.N.P. ~

Dear Parents,

Attention-Deficit/Hyperactivity Disorder (ADHD) is a chronic condition that affects at least three to nine percent of school aged children. The best approach to addressing this treatable condition is for the pediatrician to work in collaboration with the child, parents, and teachers. This collaboration includes completion of an assessment that will help to determine the extent of the problem and aid in providing a successful management plan.

The Vanderbilt Assessment Scales for parents and teachers will evaluate your child's behavior at home and at school. The questions are primarily focused on ADHD but also help to identify other behavioral difficulties that your child may be experiencing. You may find some of the questions to be difficult and you may feel some of the questions are inappropriate for your child. However, the assessment is most effective if all of the questions are answered.

When children are diagnosed with ADHD, it is important for the pediatrician to have follow-up visits with your child every three to four months to review the assessment scales, the management plan, and any prescribed medication.

Enclosed in this packet are:

- ✓ *ADHD evaluation forms for parents to complete.*
- ✓ *Vanderbilt Assessment Scale for teachers.*

Preferably, have the completed forms made available for the provider to review a week prior to your scheduled appointment. However, if this is not possible you can bring the forms with you on the day of your appointment. In the initial evaluation, you have the option to come alone or with your child. If you choose to come alone, a second appointment shortly thereafter will be necessary to bring your child and to begin treatment, if indicated. Please remember not to bring any siblings to this appointment.

Please bring any questions or concerns to your pediatrician.

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Child's Name: _____

DOB: _____ *Age:* _____ *Sex:* _____

Person Completing this form: _____

Relationship to Child: _____

Child's School: _____ *Grade:* _____

Teacher's Name and Contact Info: _____

Education Services (if any): _____

Prior ADHD Diagnosis (Please circle): YES NO

If yes, prior/current medications: _____

FAMILY

Mother: _____

Address: _____

Home Phone: _____ *Mobile Phone:* _____

Father: _____

Address: _____

Home Phone: _____ *Mobile Phone:* _____

Siblings

Name	*Age*	*Medical, Social or School Problems*

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Additional Family History

Indicate if any of the parents, grandparents, siblings, aunts, uncles or first cousins are affected by any of the following conditions:

(Please circle condition if answer is yes)

1. *Mental Retardation*
2. *Seizures*
3. *Blindness*
4. *Deafness*
5. *Early/Sudden Death*
6. *Thyroid Disease*
7. *Depression*
8. *Schizophrenia*
9. *Manic/Depressive Illness*
10. *Any Psychiatric Illness*
11. *ADD w/Hyperactivity*
12. *ADD w/o Hyperactivity*
13. *Tourette's Syndrome*
14. *High Blood Pressure*
15. *Heart Condition*

Pregnancy

*Complications (if any):*_____

_____

Smoking during pregnancy: _____

Alcohol consumption during pregnancy: _____

Medications taken during pregnancy: _____

Other "recreational" drugs: _____

Duration of pregnancy:

Premature # of weeks: _____ *Term:* _____ *Postdate # of weeks:* _____

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Medical History

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Surgeries and Hospitalizations: _____

Head Injuries: _____

Convulsions: _____ w/fever: _____ w/o fever: _____

Ear problems: _____ Eye problems: _____

Allergies or asthma: _____

Poisoning: _____

Sleep problems: _____

Appetite problems: _____

Heart Condition: _____

Present Medical Status

Present illness(es) for which child is being treated: _____

_____

Medication(s) child is currently taking on an ongoing basis:

_____

_____

Developmental Milestones:

How old was your child when he/she walked independently? _____

Talked? _____ Was toilet trained? _____