CHILD & ADOLESCENT CLINIC

CHILD AND ADOLESCENT CLINIC
www.CandAC.com

Evaluation of a Child With Attention, Learning, or Behavior Problems

Instructions to Parents

Dear Parent:

You have expressed an interest in having your child evaluated for a possible attention, behavior, or learning problem. As your Pediatricians, we will evaluate your child's problem and explore all the emotional, behavioral, and learning aspects. Even though we have included information regarding Attention Deficit Disorder in this packet, it is not automatically assumed that this is your child's diagnosis, or that your child will require medication or counseling. There are many reasons for behavior and school difficulties.

Initial Evaluation

The evaluation consists of a visit with your doctor and completing the forms found in this packet. This process will take 1-2 appointments. In this packet, you will find the following forms. If any are missing, please contact us so that we can get you the form.

1. Expanded Childhood History – this gives us important background information about your child and allows you to describe your child in your own words.
2. Initial Parent Vanderbilt Form – this is a questionnaire that you complete that helps us to diagnose ADHD and screen for other emotional and behavioral problems.
3. Initial Teacher Vanderbilt Form – this is a questionnaire that you will give to your child's teacher or teachers. The teacher will then either give it back to you or fax it to us; if your child has more than one teacher, let us know and we can give you additional forms.
4. Release of Information Form. You will sign this and take it to the school office. It gives the school permission to send us copies of your child's grades, behavior records, achievement tests, intelligence tests, and IEP, if any.

First, your doctor will talk with you and your child to get a general idea of the problem and will do a complete physical. Your doctor will look for any physical, emotional, or social conditions that may be interfering with your child's learning and school performance.

Your doctor will then review the forms in the packet to make the most accurate diagnosis and determine a treatment plan. The treatment plan may include medication, counseling, and/or educational changes.

If the forms have been completed prior to your doctor's appointment and your doctor has reviewed them, this process may be completed in one appointment. If your doctor has not received all the forms, then this process will take two appointments. If a second appointment is needed, it is important that the second appointment is made with the same doctor as the first appointment. These appointments are long, so if you cannot keep the appointment, we ask that you call at least the day before to cancel it.

Medication Review Appointments

If we prescribe medication to your child, we must see him/her often to determine that the medication dose has improved the behavior, and causes only side effects that you can live with. After the medication dose is set, we will see your child every 3 months. These are *Medication Review Appointments*. We will see how the medication is working and look at side effects. If your child has problems with behavior or learning between the times of the medication review appointments, please make an appointment to be seen sooner.

At the end of each review visit, you will be given a list of things to do before the next visit. You will be asked to get reports from your child's teacher, to bring the last report card, and to fill out a survey about how things are going. All these things are very helpful in assessing how well your child is progressing.

We will provide separate prescriptions to be filled each month until your next review appointment. The medications used for ADHD are controlled substances. We are required to handle lost medication or lost prescriptions at a new appointment because of the concern of stolen or sold prescriptions. We cannot prescribe medications for ADHD without seeing the patient for an appointment.

CHILD & ADOLESCENT CLINIC

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Attention Learning and Behavior Disorder
Expanded Childhood History
Please Use Black Ink

Child's Name: _____ Date _____

Birth Date: _____ Age: _____ Sex: _____

Person Completing Form: _____ Relationship to Child: _____

Child's School: _____

Grade: _____ Special Placement (if any): _____

Child is presently living with:

____ Biological Mother ____ Biological Father ____ Stepmother ____ Stepfather

____ Adoptive Mother ____ Adoptive Father ____ Foster Mother ____ Foster Father

____ Other (Specify) _____ Number of children in home _____

Other adults involved with this child on a regular basis: _____

_____

_____

Who suggested that your child be evaluated:

Name: _____ Relationship to child: _____

Briefly state main behavioral and learning problems of this child: _____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Name _____

PARENTS

Biological Mother: _____ **Age:** _____

Occupation: _____ Work Phone: _____

Age at time of pregnancy with patient: _____ Highest grade completed: _____

Learning problems:	□ Yes	□ No
Attention problems:	□ Yes	□ No
Behavior problems:	□ Yes	□ No

Medical Problems: _____

Biological Father: _____ Age: _____

Occupation: _____ Work Phone: _____

Age at time of pregnancy with patient: _____ Highest grade completed: _____

Learning problems:	□ Yes	□ No
Attention problems:	□ Yes	□ No
Behavior problems:	□ Yes	□ No

Medical Problems: _____

SIBLINGS:

Name	Age	Medical, social, or school problems
1.		
2.		
3.		
4.		
5.		

ADDITIONAL FAMILY HISTORY

Indicate if any of the patient's parents, brothers, sisters, aunts, uncles, grandparents, or first cousins is affected by any of the following conditions: (Please circle condition if answer is yes)

1. Intellectual Disability
2. Seizures
3. Blindness
4. Deafness
5. Early Death
6. Thyroid Disease
7. Depression
8. Schizophrenia
9. Manic/Depressive Illness
10. Any Psychiatric Illness
11. ADD with Hyperactivity
12. ADD without Hyperactivity
13. Tourette's Syndrome

Patient's Name _____

PREGNANCY

Complications: _____

Smoking during pregnancy? □ Yes _____ □ No

Alcohol consumption during pregnancy? □ Yes _____ □ No

Medications taken during pregnancy? □ Yes _____ □ No

"Recreational" drugs used during pregnancy: _____

Duration of Pregnancy:

□ Premature # Weeks: ____ □ Term □ Postdates # Weeks: ____

INFANCY PERIOD

Number of days infant was in the hospital after delivery: _____

Did your child have any problems during the first year or so of life? _____

_____

_____

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:

Operations: _____
Hospitalization for illness: _____
Head injuries: _____
Convulsions: _____ with fever _____ without fever _____
Vision or Hearing problems: _____
Anxiety: _____
Depression: _____
Sleep problems: _____
Appetite problems: _____

PRESENT MEDICAL STATUS

Present illness for which child is being treated: _____

Medications child is currently taking on ongoing basis: _____

_____

Patient's Name _____

DEVELOPMENTAL MILESTONES

How old was your child when he/she walked independently? _____ Talked? _____
Was toilet trained? _____

Do you recall having any concerns about your child's early motor or language development?

_____

COORDINATION

Do you have any current concerns about your child's current level of coordination or athletic ability? _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why? _____

_____

_____

How would you rate your child's overall level of intelligence compared to other children of the same age?

☐ Below average ☐ Above Average ☐ Average

SCHOOL

Your child's school teacher will have a separate form to complete

Do you have any concerns about your child's academic performance? _____

_____

_____

_____

When did these concerns initially develop? _____

_____

_____

Do you have concerns about your child's behavior at school? _____

_____

_____

_____

When did these concerns initially develop? _____

_____

_____

Patient's Name _____

PEER RELATIONSHIPS

Does your child seek friendships with peers? _____

Is your child sought by peers for friendship? _____

Does your child play with children primarily his/ her own age? _____ Younger? _____ Older? ____

Describe briefly any problems your child may have with peers: _____

_____

_____

_____

HOME BEHAVIOR

How is your child's behavior at home and with siblings? _____

_____

_____

Does your child have difficulty learning from his/her mistakes? _____

Types of discipline you use with your child: _____

_____

Is there a particular form of discipline that seems to work best? _____

_____

Have you participated in a parenting class or read books concerning discipline and behavior management? □ Yes If yes, list here_____ □ No

INTEREST AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____

_____

_____

What are your child's areas of greatest accomplishments? _____

_____

_____

What is your child's most positive quality? _____

_____

_____

Patient's Name _____

List names and addresses of any other professionals consulted regarding your child's behavior, including family physician or pediatricians:

1. _____
2. _____
3. _____
4. _____
5. _____

PARENTAL ASSESSMENT OF CHILD'S EMOTIONAL LEVEL

How do you see your child's social skills?

1 – Very Poor 2 - Poor 3 – Average 4 – Good 5 - Excellent

How do you see your child's mood?

1 – Very Poor 2 - Poor 3 – Average 4 – Good 5 – Excellent

How do you see your child's anger level?

1 – Not at all Angry 2 – Somewhat Angry 3 – Mildly Angry 4 – Very Angry 5 – Extremely Angry

How do you see your child's self-esteem?

1 – Very Poor 2 - Poor 3 – Average 4 – Good 5 - Excellent

Has your child ever caused major destruction of property, seriously injured another person, or seriously injured or killed an animal? □ Yes □ No

If yes, list here_____

Has your child ever broken the law and been involved with juvenile legal system because of vandalism, shoplifting, theft, assault, or any other crime? □ Yes □ No

If yes, list here: _____

Anything else you would like to share:

_____

_____

_____

_____

Please return to our office as soon as completed. Thank you!

CHILD & ADOLESCENT CLINIC

Child and Adolescent Clinic
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Attention Learning and Behavior Disorder
INITIAL ASSESSMENT FORM – PARENT/GUARDIAN
Please Use Black Ink

Child's Name: _____ Date of Birth: _____ Grade: _____ Today's Date: _____

Your Name: _____ Your Phone Number: _____

Relationship to Child: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

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. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes on others' conversations or games	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	2
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3

Child's Name _____ Date _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Has stolen things that have value	0	1	2	3
33. Deliberately destroys other's property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or care	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her:	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	4
55. Participation in organized activities (e.g., teams)	1	2	3	4	5

Total 4s, 5s

Average

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in question 1 – 9: _____	6 I
Total number of questions scored 2 or 3 in question 10 – 18: _____	6 HI
Total Symptom Score for question 1 – 18: _____	
Total number of questions scored 2 or 3 in questions 19 – 26: _____	4 OD
Total number of questions scored 2 or 3 in questions 27 – 40: _____	3 CD
Total number of questions scored 2 or 3 in questions 41 – 47: _____	3 AD
Total number of questions scored 4 or 5 in questions 48 – 55: _____	1
Average Performance Score: _____	

CHILD & ADOLESCENT CLINIC

Longview Office:
971 11th Avenue
Longview, WA 98632
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Fax: 360-423-9537

Pediatricians
Certified by the
American Board
of Pediatrics

Anne Mette Smeenk, MD
Kenneth Wu, MD
Rebecca Hutfilz, MD
Wes Henricksen, MD, MPH
Annette Ville, MD

Pediatric Nurse Practitioners
Certified by the
Pediatric Nursing
Certification Board

Robin Wulff, PNP

Vancouver Office:
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Pediatricians
Certified by the
American Board
of Pediatrics

Tsering Lhewa, MD
Amrita Stark, MD
Jennifer Chu-Smith, MD

www.candac.com

Dear Teacher:

As pediatricians, we value the collaboration of the schools and their teachers in the diagnosis and management of children with Attention Deficit Hyperactivity Disorder. It is only through direct communication and shared expertise that we can help these children become successful students.

The parents of one of your students are seeking to have their child evaluated at Child and Adolescent Clinic for a behavior or learning concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your students.

Your time and cooperation in this matter is greatly appreciated. Attached, please find a Release of Information Form that the parents have completed and a set of teacher rating scales and questionnaires.

Generally, the teacher who spends the most time with the child should complete the teacher rating scales. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales are required, please copy. Please note that the same teacher should complete each entire set of forms.

We ask that you complete these forms within one week, as we are unable to complete the child's evaluation and planned treatment without the teacher rating forms. The parents are giving you the Initial Assessment Form for the School. These forms should be returned to us by the parents or you may fax them directly to us at 360-423-9537.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, or if you would like additional information regarding services provided, please do not hesitate to write to us. If you have any other information to share, please fax it to us.

Sincerely,

Child and Adolescent Clinic

CHILD & ADOLESCENT CLINIC

Child and Adolescent Clinic
www.CandAC.com

Attention Deficit Hyperactivity Disorder
INITIAL ASSESSMENT FORM – SCHOOL
Please Use Black Ink

Teacher's Name: _____ Class Time: _____ Class Name/Subject: _____

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

Directions: PLEASE USE BLACK INK PEN. Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

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

VANDERBILT SCALE

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (e.g. butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods or favors or to avoid obligations (e.g. "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Teacher's Name: _____ Class Time: _____ Class Name/Subject: _____

Today's Date: _____ Child's Name: _____ Grade: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that no one loves him or her	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5
Classroom Behavioral Performance	**Excellent**	**Above Average**	**Average**	**Somewhat of a Problem**	**Problematic**
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Total 4s, 5s
Average

History

Learning Problems

We are interested in whether or not this child has learning problems **above and beyond** what would be expected for **his or her developmental age.**

Check the box that best describes the child's learning problems over the past 6 months	Never Rarely 0	Occa-sionally 1	Often 2	Very Often 3
1. Has trouble **learning new material** in an appropriate time frame for age and skills.				
2. Has little **desire to master** new skills.				
3. **Unable to tell time,** days of the week, months of the year.				
4. Can't **repeat information.**				
5. **Knows material one day; doesn't know it the next.**				
6. Has trouble **holding several different things in mind** while working.				
7. Has trouble **following multi-step directions.**				
8. Has difficulty **copying written material** from blackboard.				
9. Difficulty **orienting self (i.e., gets lost, can't find way, or gets turned around easily).**				
10. Has poor **spatial judgment** and often bumps into things.				
11. Confuses **directionality** (up/down, left/right, over/under).				
12. Has poor **spatial organization** on paper (difficulty staying in lines, maintaining space between words, staying within page margins).				
13. **Mixes up capital and lower** case letters when writing.				
14. **Reverses letters and numbers.**				
15. Has trouble **expressing words** or events in **correct order.**				
16. Often **mispronounces known or familiar words** or uses wrong word.				

Teacher's Name: _____ Class Time: _____ Class Name/Subject: _____

Today's Date: _____ Child's Name: _____ Grade: _____

What **grade level** work is this child doing in your subjects? _____

Check the box that best describes the child's learning problems over the past 6 months	Never Rarely 0	Occa-sionally 1	Often 2	Very Often 3
17. Has trouble **verbally expressing thoughts.**				
18. Says things that have **little or no connection to what others are discussing.**				
19. Has difficulty **distinguishing long vowel sounds and short vowel sounds.**				
20. Depends on teacher or others for **repetition of task instructions.**				
21. Displays **poor word attack skills** (can't sound out words).				
22. Puts wrong **number of letters in words.**				
23. **Confuses consonant sounds,** for example: d-b, d-t, m-n, p-b, f-v, s-v.				
24. Unable to **keep place on page** when reading.				

What **positive** or **negative coping skills** is the child using in school? _____

_____

Do you have any **additional comments** that you think would be helpful? _____

_____

What school **special services** does this child receive? _____

_____

Please return this form to: ***Child and Adolescent Clinic***

Fax Number: ***360-423-9537***

Mailing Address: ***971 11th Avenue***
Longview, WA 98632

Phone Number: ***360-577-1771***

For Office Use Only	
Total number of questions scored 2 or 3 in questions 1 – 9 _____	6 I
Total number of questions scored 2 or 3 in questions 10 – 18 _____	6 HI
Total Symptom Score for questions 1 – 18: _____	
Total number of questions scored 2 0r 3 in questions 19 – 28: _____	3 OD
Total number of questions scored 2 or 3 in questions 29 – 35: _____	3 AD
Total number of questions scored 4 or 5 in questions 36 – 43: _____	I
Average Performance Score: _____	