



"Specialist Care for Every Child"

Child and Adolescent Clinic
www.CandAC.com

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

Teacher's Name: _____ School: _____ Today's Date: _____

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

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 last assessment scale was filled out. Please 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. 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 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 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. Blurs 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

Performance
Academic Performance **Excellent** **Above Average** **Average** **Somewhat of a Problem** **Problematic**

19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following directions	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Total 4s, 5s
Average

Teacher's Name: _____ School: _____ Today's Date: _____
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Side Effects:	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite – explain how				
Trouble sleeping				
Irritability in the 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 hears things that aren't there				

Explain/Comments:**For Office Use Only**

Total Symptom Score for questions 1 – 18: _____

Average Performance Score: _____

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***