Patient Name: _____

Appointment Date: _____

ADHD EVALUATION PACKET

In order to properly evaluate your child for attention and school difficulty we need to obtain the following information both from you and your child's educator(s). Please submit all information together at least 2 WEEKS PRIOR to the initial appointment in order to allow the physician time to review and interpret the information. If we do not receive this information we may ask you to reschedule the appointment, as we cannot do an adequate evaluation without the complete packet returned.

Included in this packet you will receive the following:

For parent to complete-

- ADHD INITIAL PATIENT HISTORY This history should be completed by a parent/guardian knowledgeable about the child/family's history.

- NICHQ VANDERBILT ASSESSMENT SCALE- PARENT INFORMANT Each parent/guardian should complete his/her own survey

Give to your child's teacher(s)-

- AUTHORIZATION FOR DISCLOSURE This form should be completed by a parent/guardian and given to the teacher(s) to allow information to be shared between the clinic and teachers.

- TEACHER QUESTIONNAIRE and NICHQ VANDERBILT ASSESSMENT SCALE- TEACHER INFORMANT please give to each of your child's teacher(s) for them to complete and collect in a confidential envelope once completed (copy as needed).

Complete information at least 2 WEEKS PRIOR to your initial appointment in order for us to properly review and score the surveys. We will review this information with you and your child at the first appointment. Return completed forms to:

Hanover Pediatrics, PLLC

Please be aware that several visits and further evaluation may be needed before a diagnosis of ADHD can be made or ruled out and treatment started.

Sincerely,

Hanover Pediatrics, PLLC

INITIAL PATIENT HISTORY

ADHD

Child's Name: _____

Date of Birth: _____

Form Completed by: _____

Relationship to Child: _____

Date Completed: _____

PLEASE SUMMARIZE YOUR CONCERNS:

WHEN DID THESE PROBLEMS BEGIN?

PLEASE LIST ANY PRIOR EVALUATIONS DONE AND ATTACH RESULTS IF ABLE:

DATE:	Name of Evaluator:

INITIAL PATIENT HISTORY

SCHOOL

NAME OF SCHOOL_____
GRADE_____

PLEASE DESCRIBE YOUR CHILD'S CURRENT SERVICES THEY RECEIVE AT SCHOOL (i.e. tutors, special education classes, gifted services, etc.).

PLEASE ATTACH A COPY OF ANY Behavior Plan (formal or informal), 504, IEP OR TESTING COMPLETED.

CURRENT SERVICES:
_____
_____
_____
_____

DOES YOUR CHILD HAVE ANY IN CLASSROOM INTERVENTIONS TO ADDRESS THE FOLLOWING?

BEHAVIOR:_____
_____
_____
_____

WORK COMPLETION/HOMEWORK:
_____
_____
ACADEMIC PROGRESS:_____
_____
HANDWRITING/NEATNESS: _____
_____
CARELESS MISTAKES: _____
_____
DISTRACTION/ATTENTION: _____
_____

WHAT IS YOUR CHILD'S CURRENT AFTER SCHOOL ARRANGEMENTS:
_____
_____

INITIAL PATIENT HISTORY

HOME

PLEASE DESCRIBE ANY CONCERNS YOU HAVE ABOUT YOUR CHILD AT HOME:

_____
_____
_____
_____
_____
_____

HOW WOULD YOU DESCRIBE YOUR CHILD'S CURRENT
OVERALL MOOD_____
HOMEWORK HABITS_____
CHORE RESPONSIBILITIES/COMPLETION_____
LISTENING SKILLS_____
SLEEP HABITS_____
DIET_____
RELATIONSHIP WITH PARENTS/SIBLINGS_____
DISCIPLINE_____

WITH WHOM DOES YOUR CHILD LIVE? (IF SIBLINGS, WHAT ARE THEIR AGES?)

_____
_____
_____
_____

PARENTS ARE □ MARRIED □ DIVORCED □ SEPARATED □ NEVER MARRIED

IF DIVORCED/SEPARATED, WHAT ARE CUSTODY AND LIVING ARRANGEMENTS?

_____

WHAT ARE THE CURRENT FAMILY STRESSORS?

_____
_____

INITIAL PATIENT HISTORY

SOCIAL

ARE THERE ANY FRIENDSHIP CONCERNS? ANY TROUBLE MAKING OR KEEPING FRIENDS?

_____
_____
_____
_____

ARE THERE ANY CONCERNS REGARDING YOUR CHILD'S SELF ESTEEM/CONFIDENCE?

_____
_____
_____
_____

WHAT ORGANIZED ACTIVITIES DOES YOUR CHILD PARTICIPATE IN AND HOW OFTEN? (i.e. sports, music, religion, scouts)

_____
_____
_____
_____

HOW OFTEN AND FOR HOW LONG DOES YOUR CHILD WATCH TV/PLAY VIDEO GAMES?

_____
_____
_____

WHAT DOES YOUR CHILD DO THAT HE/SHE FEELS GOOD ABOUT?

_____
_____
_____
_____

INITIAL PATIENT HISTORY

MEDICAL

HAVE YOU OR YOUR CHILD'S PHYSICIAN EVER HAD CONCERNS REGARDING THE FOLLOWING?

IF SO, AT WHAT AGE?

	YES	NO	AGE	COMMENTS
PREMATURE BIRTH DEVELOPMENT GROWTH				
WEIGHT LOSS WEIGHT GAIN HEAD SIZE				
SPEECH DEVELOPMENT				
APPETITE				
SLEEP				
HEADACHES				
STOMACH ACHES				
RECURRENT VOMITING				
TICS				
FAINTING				
CHEST PAIN				
TROUBLE BREATHING				
ASTHMA				
CONSTIPATION				
URING OR STOOL ACCIDENTS DAY				SPECIFY:
URINE OR STOOL ACCIDENTS NIGHT				SPECIFY:
DIARRHEA				
HAIR LOSS				
HEARING PROBLEMS				
VISION PROBLEMS				
HEAD INJURY				DATE:
DEPRESSION				
CHEMICAL DEPENDENCY				SPECIFY:
ANXIETY				
OTHER				

MEDICAL CONT'D

PLEASE LIST ANY CHRONIC OR SERIOUS MEDICAL CONCERNS:

DATE	MEDICAL CONCERNS

CURRENT MEDICATIONS (INCLUDING VITAMINS/HERBALS/SUPPLEMENTS/ESSENTIAL OILS):

MEDICATION/HERB/SUPPLEMENT/OIL	DOSAGE/FREQUENCY

ANY FAMILY MEMBERS (MOTHER/FATHER/AUNT/UNCLE/SIBLING/GRANDPARENTS) HAVE DIFFICULTY WITH THE FOLLOWING:

	RELATIONSHIP TO CHILD	COMMENTS
LEARNING PROBLEMS		
MENTAL DISABILITY		
DEPRESSION		
ANXIETY		
OTHER MENTAL HEALTH		SPECIFY:
AUTISM		
SEIZURE DISORDER		
GENETIC CONDITION		SPECIFY:
OTHER		SPECIFY:
OTHER		SPECIFY:

ALLERGIES TO MEDICATIONS, FOODS, POLLENS, ETC:

□ YES: _____

□ NONE

IMMUNIZATIONS UP TO DATE?

□ YES

□ NO

DATE: _____

CHILD'S NAME_____

PARENT'S NAME_____

Dear Teacher/Counselor,

We are currently evaluating one of your students. In order to complete this evaluation we are asking you to complete the following questionnaire and rating scale. Each teacher should complete a separate questionnaire and survey. Once completed please return the form to the parent in a sealed confidential envelope as soon as possible so it can be returned to us.

In addition to the questionnaire and survey, it would be helpful to receive copies of any evaluations done at the school. These may include achievement tests or educational assessments, behavior plans, IEP reports, 504 plans, or school psychologist reports.

A signed Authorization for Disclosure of Protected Health Information by the parent/guardian is also enclosed.

Thank you for your assistance and cooperation in the completion of these forms. Please call if you have any questions regarding the enclosed material.

Sincerely,

Hanover Pediatrics, PLLC

TEACHER QUESTIONNAIRE

Child's Name_____

School Name_____

Teacher's Name_____

Hours with child (daily average)_____

Number of students in class _____

How long have you known this child? _____

Is this child absent often? _____

Has this child repeated/skipped any grades? _____

Date Completed_____ Child's Grade_____ Subject Taught_____

Has this child had any or planned to have any IQ or educational assessments?_____

If so, what is the child's Full IQ_____ Verbal IQ_____ Performance IQ_____

Does this child have an IEP? _____

(if so please attach copy of most recent).

Please describe any special help/services this child receives in and outside of the classroom including intervention team/response to intervention plans:

_____
_____
_____
_____
_____

Please rate the child's ability in the following for his/her grade level:

	Failing	Below Average	Average	Above Average	Superior
Reading					
Arithmetic					
Spelling					
Handwriting					
Written Expression					
Overall academic achievement					
Social Interactions					

PLEASE DESCRIBE THIS CHILD'S STRENGTHS AND DIFFICULTIES AS YOU SEE THEM.

_____
_____
_____
_____
_____

PLEASE LIST ANY SPECIFIC QUESTIONS AND/OR AREAS IN WHICH YOU WOULD LIKE TO HELP THIS CHILD.

_____
_____
_____

ANY ADDITIONAL COMMENTS.

_____
_____
_____

Authorization for Disclosure of Protected Health Information

(Please sign and give to your child's teacher(s))

_____

Child's Name

_____

Birth Date

I hereby authorize the school below to release information to and receive assessment results from:

_____
School

_____
Contact Person Title

_____
Telephone #

_____
Address

_____
City State Zip

Information to be released to Hanover Pediatrics, PLLC at:

1904 Tradd Court, Wilmington, NC 28401

Information being requested:
☑Teacher Questionnaire
☑NICHQ Vanderbilt Assessment
☑Recent psychometric, academic, any current IEP/504, behavior plan in use and behavioral assessments

Other: _____

_____
Signature of Guardian/Parent