NICHQ Vanderbilt Assessment Follow Up –TEACHER Informant

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

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

Directions: 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. 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?

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 misunderstand)	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/her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Total Symptom Score for question #'s 1-18: _____

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 Direction	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

Average Performance Score: _____

-Please Turn Over-

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Pittsburgh Side-Effects Rating Scale

Directions: Listed below are several possible negative effects (side effects) that medication may have on a child with ADHD. Please read each item carefully and use the boxes to rate the severity of this child's side effects during your contact with him or her today. When requested, or wherever you feel it would be useful for us to know, please describe the side effects that you observed or any other unusual behaviors in the "Comments" section below. The same person should complete this scale each time it is completed.

Use the following to assess severity:

None: The symptom is assessed and is found absent.

Mild: The symptom is present but is not sufficient to cause concern to the child, peers, or adults and would not affect a decision to recommend medication.

Moderate: The symptom causes impairment of functioning or social embarrassment to a degree that the benefits of medication must be considerable to justify the risks of continuing medication.

Severe: The symptom causes impairment of functioning or social embarrassment to a degree that the child should not continue to receive medication as part of treatment.

	None	Mild	Moderate	Severe
Motor Tics—repetitive movements: jerking or twitching (e.g., eye blinking-eye opening, facial or mouth twitching, shoulder or arm movements)—please describe below				
Buccal-lingual movements: Tongue thrusts, jaw clenching, chewing movement besides lip/cheek biting-please describe below				
Picking at skin or fingers, nail biting, lip or cheek chewing—please describe below				
Worried/Anxious				
Dull, tired, listless				
Headaches				
Stomachache				
Crabby, Irritable				
Tearful, sad, depressed				
Socially withdrawn—decreased interaction with others				
Hallucinations (sees or hears things that aren't there)				
Loss of appetite				
Trouble sleeping (time went to sleep)				

Comments:

PLEASE RETURN THIS FORM TO: _____

MAILING ADDRESS: _____

_____

FAX NUMBER: _____