

Parent/Childhood Observer ADHD Questionnaire

Date:	
Patient Name:	Patient Birthdate:
Parent/Adult Name:	Parent/Adult Phone #:
Do you feel that the above person had impairing issues with ADHD as a child? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, then at what grade in school do you feel the problems started?	
Did this person receive additional help? IEP <input type="checkbox"/> 504 <input type="checkbox"/> Other	
Has this person had educational testing? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, by whom?	
Results of testing:	
Is there any family history of ADHD or learning disabilities? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please describe:	

NICHQ Vanderbilt Assessment Follow-up – PARENT Informant

Please check the box that best describes your child **between the ages of 7 and 11**. Please provide examples when you rate a symptom as occurring often or very frequently. Examples may describe **home, school and social environments**.

When elementary school age, the student being described...	Never 0	Occasio nally 1	Often 2	Very Often 3
1. Does not pay attention to details or makes careless mistakes, for example homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
2. Has difficulty sustaining attention to tasks or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
3. Does not seem to listen when spoken to directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
5. Has difficulty organizing tasks and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
7. Loses things necessary for tasks or activities (school assignments, pencils or books)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Examples/details:				
8. Is easily distracted by extraneous stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
9. Is forgetful in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
10. Fidgets with hands or feet or squirms in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
11. Leaves seat when remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
12. Runs about or climbs excessively in situations when remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
13. Has difficulty playing or engaging in leisure/play activities quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
14. Is "on the go" or often acts as if "driven by a motor"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
15. Talks too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
16. Blurts out answers before questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
17. Has difficulty waiting his/her turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
18. Interrupts or intrudes on others (e.g., butts into conversations or games)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:				
Is there any additional information that is relevant to this student's ADHD assessment? If so, please describe:				

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Overall performance... (ages 7-11)	Excellent	Above Average	Average	Somewhat of a problem	Problematic
	1	2	3	4	5
19. Overall school performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Mathematics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Relationship with parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Relationship with siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Relationship with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Participation in organized activities (eg. Teams)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developmental History:	
History of complications during pregnancy/delivery/1 st days after birth? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please describe:	
Delivery was: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section	Number of days in the hospital after birth:
Was Neonatal ICU Required? <input type="checkbox"/> YES <input type="checkbox"/> NO	
At what age did they say first words?	First sentences?
Any problems learning to read or write? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Did teachers ever express concern? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Any testing for speech, language, occupational therapy, or learning difficulties? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Any difficulty with scissors, eating utensils or holding a pencil? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Any history of heart disease in them? <input type="checkbox"/> YES <input type="checkbox"/> NO Other medical concerns? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe:	
Has he or she ever fainted during exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe:	
Have any family members died from sudden cardiac death before the age of 50? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Any history of neurological disorders such as seizures? <input type="checkbox"/> YES <input type="checkbox"/> NO Tics/Tourette's <input type="checkbox"/> YES <input type="checkbox"/> NO	