

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

Teacher's Name: _____ School: _____ Grade: _____

Each rating should be considered in the context of what is appropriate for the age of the child you are rating.

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. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3	
2. Has difficulty sustaining attention to task 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 task and activities	0	1	2	3	
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental efforts	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	<input type="checkbox"/> Count # 2s + 3s
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 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 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	<input type="checkbox"/> Count # 2s + 3s
18. Interrupts or intrudes in others' conversations and/or activities	0	1	2	3	<input type="checkbox"/> TSS 1-18

IMPAIRMENT	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
A. Reading	1	2	3	4	5	
B. Mathematics	1	2	3	4	5	
C. Written Expression	1	2	3	4	5	
D. Relationship with peers	1	2	3	4	5	
E. Following directions	1	2	3	4	5	
F. Disrupting class	1	2	3	4	5	
G. Assignment completion	1	2	3	4	5	<input type="checkbox"/> Count # 4s + 5s
H. Organizational skills	1	2	3	4	5	<input type="checkbox"/> APS 19-26

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

FAX OR MAIL COMPLETED FORM TO: (Check one office/location)

<input type="checkbox"/>	(Enter practice contact information) Name of Practice Street Address Phone Number/Fax Number	<input type="checkbox"/>	(Enter practice contact information – 2 nd office/location) Name of Practice Street Address Phone Number/Fax Number
<input type="checkbox"/>	(Enter practice contact information – 3 rd office/location)	<input type="checkbox"/>	(Enter practice contact information – 4 th office/location)

-Please Turn Over-

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

Teacher's Name: _____ School: _____ Grade: _____

Side-Effects Rating Scale

Instructions: Listed below are several possible negative effects (side effects) that medication may have on an ADHD child. Please read each item carefully and use the boxes to rate the severity of the child's side effects he/she has been on his/her current dose of medication. 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 behavior in the "Comments" section below.

Use the following to assess severity:

- None: The symptom is not present.
- Mild: The symptom is present but is not significant enough to cause concern to the child, to you, or to his/her friends. Presence of the symptom at this level would NOT be a reason to stop taking the medicine.
- Moderate: The symptom causes impairment of functioning or social embarrassment to such a degree that the negative impact on social and school performance should be weighed carefully to justify benefit of continuing medication must be considered.
- Severe: The symptom causes impairment of functioning or social embarrassment to such a degree that the child should not continue to receive this medication or dose of medication as part of current 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)—describe below				
Buccal—lingual movements: Tongue thrusts, jaw clenching, chewing movement besides lip/cheek biting— describe below				
Picking at skin or fingers, nail biting, lip or cheek chewing – describe below				
Worried/Anxious				
Dull, tired, listless				
Headaches				
Stomachache				
Crabby, Irritable				
Tearful, Sad, Depressed				
Socially withdrawn – decreased interaction with others				
Hallucinations (see or hear things that aren't there)				
Loss of appetite				
Trouble sleeping (time went to sleep)				

Adapted from the Pittsburgh Side-Effects Rating Scale

COMMENTS: