Welcome to Attention-MD!

We provide evidence-based evaluations and treatment for children and adolescents with attention and learning issues like Attention-Deficit Hyperactivity Disorder (ADHD), and address the challenges that these children and their families face. Our evaluation is comprehensive, and we want to begin to get to learn about your child's difficulties before you arrive for your first visit!

Please complete the following forms and feel free to give as much information as possible. Having this information before your appointment helps us use the time at your visit to better fully address your concerns.

We combine the information in this packet and the information you provide during your appointment with our FDA-cleared objective test to help arrive at a more accurate and efficient diagnosis.

Whether your child is ultimately diagnosed with ADHD and/or some related condition, we provide support and recommendations to help you address your child's difficulties and your concerns.

At the initial evaluation, an evidenced based diagnosis can usually be provided, and specific therapy options will be recommended.

If medical treatment is suggested during the evaluation, we will fully explain our recommendations and provide the same careful attention to medication treatment that we do to making a diagnosis. Most often both medication and behavioral therapy options will be presented.

After any diagnosis and treatment plan is suggested, our clinic will provide careful follow-up to ensure that your child is making progress. We will discuss a follow-up plan with you during your first visit.

Thank you for choosing Attention-MD. We are committed to taking you and your family "from frustration to focus".

Patient Information Sheet

First: _____________________________ Middle: ________Last Name: ____________________________

Nickname: _________________ Date of Birth: ______ Gender/Pronouns: M/F/U_________

Patient Mailing Address: ____

City:_ ___________________________ State: _________ Zip Code: __________`

Current School/Grade____

How did you hear about Attention-MD? (Please Circle) Friend/Relative Doctor Referral: ___________
Facebook Internet Search/Google Other

Parent/Guardian Information
Name of Parent/Legal Guardian: ____

Relationship to patient: __________________________ Email address: _________________________________

Parent/Guardian Cell Phone no. _____________________________________

Mailing Address (if not the same as above): _______________________________________

City: ____________________ State: ____ Zip: ________

Is the above listed parent/guardian responsible for patient's financial account? o Yes o No /If no, please complete:
Responsible party: __________________________________ Date of Birth: ___________
Mailing Address _________________________________City: ____________________ State: ____ Zip: ________

Primary Insurance Information: (This is just for reference, we do not bill claims to commercial insurance policies) Insurance Carrier: ___________________________ID #: _______________Group #: ________________
Policy Holder's Name ______________________________
Policy Holder's Date of Birth: _____________Relationship to patient ______________________

Primary Care Physician: Name ____

Address ______________________________ City ___________ State ____ Zip ___________

Referring Professional: Name _______________________________ Phone ________________ Address __________________________ City ______________________ State ______ Zip________

Preferred Pharmacy Name ___________________________Phone_____________________ Address _______________________________City _____________________ State ______ Zip _______

PATIENT HISTORY

- Name of person completing this form: Relationship to patient: ______________________
- What are your main concerns regarding the patient?
  For example: inattention, distractibility, hyperactivity, impulsivity, academic problems, oppositional behavior, anxiousness

____

____

____

____

Patient Name: ______________________

Help Us Get to Know Your Child

Parents, please have your CHILD complete this questionnaire *BY HAND*. We use this as a writing sample for the child. If your child cannot write, please ask them the questions and record their response.

What do you do well?

What do you enjoy doing most?

What is your favorite thing about school?

What is your least favorite thing about school?

Is it hard for you to sit still?

Is it hard to wait your turn? If you have to wait in line, or if you want to give an answer, is that hard for you?

Does your teacher think you talk too much?

Is it hard to pay attention to the teacher?

Is it hard to keep up with things like pencils, books, jackets, or sports equipment? Is homework hard to finish?

Do you or your parents ever cry or yell over doing homework?

Do you have a good friend at school?

Do you worry a lot?

Are you sad a lot?

Patient Name: ______________________

REVIEW OF SYSTEMS:

Constitutional
- Yes No Decreased Appetite
- Yes No Decreased Appetite at Lunch
- Yes No Excessively Sleepy
- Yes No Fatigue
- Yes No Problems Falling/Staying Asleep
- Yes No Tired
- Yes No Weight Gain
- Yes No Weight Loss

Eyes
- Yes No Frequent Blinking/Squinting
- Yes No Itching/Rubbing Eyes
- Yes No Vision Problems

Ears/Nose/Throat
- Yes No Hearing Loss
- Yes No Large Tonsils
- Yes No Snoring

Respiratory
- Yes No Cough at Night/Wakes Patient
- Yes No Frequent Cough
- Yes No Shortness of Breath
- Yes No Tightness in Chest
- Yes No Trouble Breathing

Heart/Vascular
- Yes No Chest Pain
- Yes No Heart Racing/Fast Heart Rate
- Yes No High Blood Pressure
- Yes No Palpitations

Gastrointestinal
- Yes No Blood in Stool
- Yes No Constipation
- Yes No Diarrhea
- Yes No Frequent Abdominal Pain
- Yes No GERD/Reflux/Frequent Heartburn
- Yes No Stool Leakage/Accidents
- Yes No Vomiting

Musculoskeletal
- Yes No Clumsy
- Yes No Joint Pain
- Yes No Limp or Gait Disturbance

Psychiatric
- Yes No Aggression
- Yes No Anxious, Worries
- Yes No Apathetic/Lazy
- Yes No Attempts at Self Harm, Suicide
- Yes No Cutting Behavior
- Yes No Depressed, Sad
- Yes No Flat Effect/Zombie-like

Psychiatric
- Yes No Frequent Anger
- Yes No Hypersexual Behavior
- Yes No Irritable, Touchy
- Yes No Low Self Esteem
- Yes No Mood Issues Related to Menstruation
- Yes No Not Sleeping for over 24 Hours
- Yes No Obsessive Compulsive Behaviors
- Yes No Overly Confident or Grandiose
- Yes No Paranoid, hears/sees things others don't
- Yes No Racing Thoughts
- Yes No Rigid, Inflexible
- Yes No Sensory Issues- Hates Tags, Loud Noises, Problems with Food Textures
- Yes No Special Abilities
- Yes No Thoughts of Self Harm, Suicide

Skin/Hair/Nails
- Yes No Acne
- Yes No Eczema
- Yes No Hair Loss
- Yes No Sores or Rashes
- Yes No Twirls or Pull Hair/Picks at Skin, Nails

Neurological
- Yes No Blank Staring Spells
- Yes No Frequent Headaches
- Yes No Motor Tics – Blinking, Jerking
- Yes No Seizures
- Yes No Tremor
- Yes No Verbal Tics – Sniffing, Throat Clearing, Vocalizing
- Yes No Weakness

Endocrine
- Yes No Diabetes
- Yes No Frequent Urination/Drinks Excessive Fluids
- Yes No Problems with Growth/Short Stature
- Yes No Thyroid Problems

Heme/Lymph
- Yes No Anemia
- Yes No Easily Bruised

Allergic/Immunologic
- Yes No Allergies
- Yes No Asthma
- Yes No Food Allergy

Genito/Urinary
- Yes No Bed Wetting
- Yes No Frequent Urinating
- Yes No Irregular, Heavy Period
- Yes No Significant Menstrual Pain
- Yes No Urine Accident/Incontinence

ALLERGIES:

Does the child have any drug allergies? ☐Yes ☐No
If yes, please name the drug: ____

Does the child have any food allergies? ☐Yes ☐No
If so, please name the food(s): ____

CURRENT ADHD MEDICATIONS:

ADHD Medication Name (1): ________________________________Dose: _____mg

Time taken: am/pm

How effective is this medication? ☐not effective ☐somewhat effective ☐effective ☐very effective

The medication is taken: ☐Almost every day ☐School/work days ☐Less than 5 days a week

The medication lasts: ☐< 6 hours ☐6-8 hours ☐8-10 hours ☐10-12 hours
This duration of the action is: ☐adequate ☐not adequate

ADHD Medication Name (2): ________________________________Dose: _____mg

Time taken: am/pm

How effective is this medication? ☐not effective ☐somewhat effective ☐effective ☐very effective

The medication is taken: ☐Almost if not every day ☐School/work days ☐Less than 5 days a

The medication lasts: ☐< 6 hours ☐6-8 hours ☐8-10 hours ☐10-12 hours
The duration of the action is: ☐adequate ☐not adequate

CURRENT OCD/ANXIETY/MOOD MEDICATIONS:

Medication Name: ___________________________ Dose: _____mg Time taken: am/pm
How effective is this medication? ☐not effective ☐somewhat effective ☐effective ☐very effective

OTHER CURRENT MEDICATIONS: ____

PAST ADHD MEDICATIONS:

Medication Name: ___________________ Effective (Y/N) Side Effects: ______________________

Medication Name: ___________________ Effective (Y/N). Side Effects: ______________________

FAMILY HISTORY: Please indicate with and X if any of your immediate family members have experienced any of the following conditions. Initial if none:___________

	Mother	Father	Sibling 1	Sibling 2	Grandparent	Aunt/Uncle
ADHD						
Learning Disorder						
Anxiety						
Panic Disorder						
OCD						
Mood Disorder						
Bipolar Disorder						
Depression						
Schizophrenia						
Tics/Tourette's						
Headache/Migranes						
Autism/Asperger's						
Seizure Disorder						
Addiction/Substance Abuse						
Heart Disease Under Age 40						
High Blood Pressure						
Stroke						
Diabetes						
Cancer						
Asthma						

	Age	***Career/Grade***	***Employer/School***
Parent 1			
Parent 2			
Sibling 1 M/F			
Sibling 2 M/F			
Sibling 3 M/F			

MEDICAL HISTORY:

Newborn History

- Were there any pregnancy complications? Yes /No
  ☐ Preterm Labor ☐ Meds During Pregnancy ☐ Drug/Alcohol use During Pregnancy
  ☐ Other Exposure During Pregnancy ☐ Infection During Pregnancy ☐ Hypertension ☐ Diabetes

  Fertility Assistance? Yes/No

- Length of pregnancy? Term/ Premature /Overdue # Weeks: ____
- Birth Hospital __________________ Birth Weight _________
- Type of delivery: ☐ C-Section ☐ Vaginal ☐ Vacuum Assisted ☐ Forceps Assisted ☐ Meconium
- Were there any delivery complications? ☐ Yes ☐ No

  ☐ Difficult Delivery ☐ Nuchal Cord ☐ Hemorrhage

- Were there any problems after delivery? ☐ Yes ☐ No

  ☐ Jaundice ☐ Breathing Problems ☐ Bleeding in Brain ☐ Bowel Problems ☐ Sepsis/Infection

Infant History

Mark all that apply: ***Temperament*** ☐ Happy ☐ Fussy ☐ Active ☐ Quiet ☐ Colic ☐ Social with People

☐ Anxious around people

Nutrition ☐ Breast Milk ☐ Regular Formula ☐ Special Formula (Brand) __________

Sleep ☐ Good sleeper ☐ Sleep difficulty ☐ Easy to Soothe ☐ Hard to Soothe

Toddler History

Mark all that apply: ☐ Typical interests ☐ Special interests ________

☐ Quiet ☐ Separation difficulty ☐ Active ☐ Very Active ☐ Explosive tantrums. ☐ Scary Active

Preschool History

☐ Cooperative with Teachers/Children. ☐ Difficult with Teachers/Children
☐ Good with letters/numbers/colors/rhymes ☐ Trouble with letters/numbers/colors/rhymes

Developmental History:

Please mark when the child achieved the following milestones: (E = early, A = average, or L = late)

Speech/Language (single words, sentences) ________

Fine Motor Skills (stacking blocks, thumb-finger grasp, drawing circle) ________

Gross Motor Skills (rolling over, standing, walking) ____________

Toilet Training ___________

Sleep History:

- Does the child have a history of sleeping problems? (since infant/toddler years) Yes/ No

  ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep ☐ Sleep Walking ☐ Talking in Sleep

  ☐ Frequent Nightmares ☐ Frequent Night Terrors ☐ Vivid Dreams

- Has the child gone longer than 24 hours without sleep? ☐ Yes ☐ No
  If yes, did the child seem tired the next day? ☐ Yes ☐ No
  How often has this occurred? _______________
  What is the maximum number of days the child has gone without sleep? _______________
- Does the child sleep after school? ☐ No ☐ Yes, Daily ☐ Yes, Occasionally
  - How long does he/she sleep? _____________
- Does the child seem tired during the day? ☐ Yes ☐ No
- Does the child fall asleep during the day? ☐ Yes ☐ No

Behavioral/Mental Health History:

- Has the child ever been formally diagnosed with ADHD? If yes, when was he/she diagnosed and by whom? ____
  - Do you have documentation of the diagnosis? ☐ Yes ☐ No
  - Is he/she currently under a provider's care for ADHD? ☐ Yes ☐ No
    Why are you changing ADHD providers? ____
- Has the child ever received IQ or Academic Testing? ☐ Yes ☐ No

• Diagnosed with Dyslexia, Learning Disability , or Other Diagnosis _______________________
• Has the child ever participated in counseling, behavioral modification, or therapy? ☐ Yes ☐ No

If so, please explain:
____
____

• Has the child every experienced any of the following conditions or symptoms?

- Depression (sad, irritable, hopeless, tearful, lack of interest, social withdrawal) ☐ Yes ☐ No
- Anxiety (worry, fearful, obsessive thoughts, frequent headaches/stomach aches) ☐ Yes ☐ No
- Behavioral problems (defiance, argumentative, refusals, anger, aggression, school suspensions or detentions) ☐ Yes ☐ No

- Verbal tics (throat clearing, repeating words) ☐ Yes ☐ No
- Motor tics (blinking, face muscle twitching) ☐ Yes ☐ No

General Medical History

Has the child been hospitalized? ☐ Yes ☐ No
If yes, please explain:____

- Has the child ever had a concussion or head injury? ☐ Yes ☐ No If yes, date: _________
- How is the child's vision? ☐ Normal ☐ Vision impairment ☐ Wear corrective lenses or contacts
- How is the child's hearing? ☐ Normal ☐ Some hearing impairment ☐ Uses hearing aid

Please check if the child has ever experienced any of the following symptoms or conditions

☐ *Heart Murmur*	☐ *Cardiac Abnormalities*	☐ *Asthma/Allergies*
☐ *Enuresis (Daytime Accident)*	☐ *Bedwetting*	☐ *Encopresis (soiling w/ stool)*
☐ *Constipation/Diarrhea*	☐ *Thyroid Problems*	☐ *Frequent Ear Infections*
☐ *Seizures*	☐ *Reflux*	☐ *Headaches*
☐ *Diabetes*		

Surgical History

- Tubes ☐ Yes. ☐ No. # Sets _________ 1st Set at what age? __________
- Adenoidectomy ☐ Yes ☐ No
- Tonsillectomy ☐ Yes ☐ No
- Appendectomy ☐ Yes ☐ No
- Other surgery: ____

Social History

Is the patient your biological child? ☐ Yes ☐ No

- If adopted, when was he/she adopted (what age)? ___________
- Has the child ever been the victim of abuse or neglect? ☐ Yes ☐ No
- Parent Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married

- The patient lives with: ☐ Parents ☐ Mom ☐ Dad ☐Mom/Step-dad ☐ Dad/Step-mom ☐ Grandparent ☐ Other relative/Non-relative
  If child does not live with both parents, how often does the child see the non-custodial parent?
  ☐ Frequently/equally ☐ At least weekly ☐ Rarely ☐ No relationship
  ☐ Every other week ☐ Monthly ☐ Less than monthly
- Does the child have a consistent nighttime routine? ☐ Yes ☐ No
  ☐ Has a TV in the bedroom ☐ Watches TV/uses electronics before bedtime

  Usual bed time: _____________ Usual wake time: __________

- Does the child have any dietary restrictions? Yes, Explain. _________________________
  - ☐ Regular diet ☐ Vegetarian ☐ Other __________________________
- How would you rate the child's physical activity level?
  ☐ Very active ☐ Active ☐ Somewhat active ☐ Not active/couch potato
- How many caffeinated beverages does the child drink each day? ☐ None ☐ <1
  ☐ 1-3perday ☐ 3+perday
- Where does the child attend school? ____________________ Grade ______
- How is the child's academic performance? ☐ Good ☐ Fair ☐ Poor ☐ Failing/Danger of failing
  ☐ Problems with reading ☐ Problems with writing ☐ Problems with math
  ☐ No Problem ☐ Somewhat of a problem ☐ Moderate Problem ☐ Significant Problem
- How is the child's school behavior? ☐ Good ☐ Disruptive ☐ Oppositional ☐ Meltdowns

• Does the child receive any school-based accommodations? Yes No Needed, but reluctant to use

- ☐ Resource classroom ☐ Individual testing ☐ IEP ☐ Reduced work volume
- ☐ 504 Plan accommodation ☐ Response to intervention ☐ Extended time on testing
- ☐ Informal accommodations ☐ Testing in a quiet environment ☐ Other: _______________

Does the child have any hobbies or activities they enjoy? Yes No

- ☐ Sports/athletics ☐ Hunting/Fishing/Outdoors ☐ Music/Band ☐ Video Games ______ Hours per day
- ☐ Drama ☐ Social Media _________ Hours per day☐ Martial arts ☐ TV/ Media __ Hours per day
- ☐ Art/Creative writing ☐ Electronic/Social Media time is a problem

Describe the child's after school routine: ☐ Tutoring/Educational Intervention ☐ After school care
☐ Unstructured ☐ Car Rider ☐ Sports/Physical Activity ☐ Rides Bus ☐ Homework is done after school
☐ Homework is delayed until evening

- How is the child's behavior at home?
    - ☐ Good behavior ☐ Homework problems ☐ Problems with time management
    - ☐ Oppositional behavior ☐ Problems with task completion ☐ Disrespectful behavior
    - ☐ Meltdowns

☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

• How are the child's relationships with family members?

- ☐ No unusual stress ☐ More than usual conflict with siblings ☐ Parent/child conflict
- ☐ Step-parent/child conflict ☐ Conflict with non-custodial parent ☐ Conflict with custodial parent
- ☐ Conflict with other family members

☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

•How are the child's relationships with peers?

☐ Healthy, identified friends ☐ Limited Friendships ☐ Doesn't identify friends
☐ Some Conflicts ☐ Significant conflict ☐ Problems making/keeping friends

☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

• Have there been any bullying issues?

☐ No Problems ☐ Child is teased/picked on ☐ Child bullies others ☐ Bullying is ongoing

☐ Bullying is being addressed

☐ Somewhat of a problem ☐ Moderate problem ☐ Significant problem

Have there been any major stressors for the patient in the past year?

- ☐ Family conflict ☐ Absent parent
- ☐ Peer relationships ☐ Serious illness in the family
- ☐ School performance ☐ Death in the family
- ☐ Sibling relationships ☐ Natural disaster
- ☐ Financial stressors ☐ Loss of housing
- ☐ Substance abuse in home ☐ Other_______________________________________

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ________ Child's Name: ______________________ Date of Birth: ____________

Parent's Name: ______________________ Parent's Phone Number: ______________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

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 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 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 or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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

Revised - 1102

American Academy of Pediatrics

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NICHQ

National Initiative for Children's Healthcare Quality

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued

Today's Date: ___________ Child's Name: ____ Date of Birth: _______________

Parent's Name: ____ Parent's Phone Number: _____________________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ____________________

Total number of questions scored 2 or 3 in questions 10–18: ____________________

Total Symptom Score for questions 1–18: ____________________

Total number of questions scored 2 or 3 in questions 19–26: ____________________

Total number of questions scored 2 or 3 in questions 27–40: ____________________

Total number of questions scored 2 or 3 in questions 41–47: ____________________

Total number of questions scored 4 or 5 in questions 48–55: ____________________

Average Performance Score: ____________________

D4 NICHQ Vanderbilt Assessment Scale—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. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks 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 tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	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
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 excessively in situations in which 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 excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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

Revised - 0303

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NICHQ National Institute for Children's Health Quality

HE0351

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

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

Today's Date: ________ Child's Name: ____________ Grade Level: ____________

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: ____________________

Mailing address: ____________________

____

Fax number: ____________________

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ____________

Total number of questions scored 2 or 3 in questions 10–18: ____________

Total Symptom Score for questions 1–18: ____________

Total number of questions scored 2 or 3 in questions 19–28: ____________

Total number of questions scored 2 or 3 in questions 29–35: ____________

Total number of questions scored 4 or 5 in questions 36–43: ____________

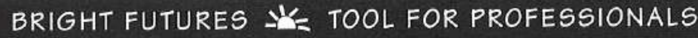
Average Performance Score: ____________

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

11-20/rev0303



Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

			Never	Sometimes	Often
1.	Complains of aches and pains	1	___	___	___
2.	Spends more time alone	2	___	___	___
3.	Tires easily, has little energy	3	___	___	___
4.	Fidgety, unable to sit still	4	___	___	___
5.	Has trouble with teacher	5	___	___	___
6.	Less interested in school	6	___	___	___
7.	Acts as if driven by a motor	7	___	___	___
8.	Daydreams too much	8	___	___	___
9.	Distracted easily	9	___	___	___
10.	Is afraid of new situations	10	___	___	___
11.	Feels sad, unhappy	11	___	___	___
12.	Is irritable, angry	12	___	___	___
13.	Feels hopeless	13	___	___	___
14.	Has trouble concentrating	14	___	___	___
15.	Less interested in friends	15	___	___	___
16.	Fights with other children	16	___	___	___
17.	Absent from school	17	___	___	___
18.	School grades dropping	18	___	___	___
19.	Is down on him or herself	19	___	___	___
20.	Visits the doctor with doctor finding nothing wrong	20	___	___	___
21.	Has trouble sleeping	21	___	___	___
22.	Worries a lot	22	___	___	___
23.	Wants to be with you more than before	23	___	___	___
24.	Feels he or she is bad	24	___	___	___
25.	Takes unnecessary risks	25	___	___	___
26.	Gets hurt frequently	26	___	___	___
27.	Seems to be having less fun	27	___	___	___
28.	Acts younger than children his or her age	28	___	___	___
29.	Does not listen to rules	29	___	___	___
30.	Does not show feelings	30	___	___	___
31.	Does not understand other people's feelings	31	___	___	___
32.	Teases others	32	___	___	___
33.	Blames others for his or her troubles	33	___	___	___
34.	Takes things that do not belong to him or her	34	___	___	___
35.	Refuses to share	35	___	___	___

Total score ____________

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?____________________________________

www.brightfutures.org

17

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: ____________________ Date: ____________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	PN
2. I get headaches when I am at school.	O	O	O	SH
3. I don't like to be with people I don't know well.	O	O	O	SC
4. I get scared if I sleep away from home.	O	O	O	SP
5. I worry about other people liking me.	O	O	O	GD
6. When I get frightened, I feel like passing out.	O	O	O	PN
7. I am nervous.	O	O	O	GD
8. I follow my mother or father wherever they go.	O	O	O	SP
9. People tell me that I look nervous.	O	O	O	PN
10. I feel nervous with people I don't know well.	O	O	O	SC
11. I get stomachaches at school.	O	O	O	SH
12. When I get frightened, I feel like I am going crazy.	O	O	O	PN
13. I worry about sleeping alone.	O	O	O	SP
14. I worry about being as good as other kids.	O	O	O	GD
15. When I get frightened, I feel like things are not real.	O	O	O	PN
16. I have nightmares about something bad happening to my parents.	O	O	O	SP
17. I worry about going to school.	O	O	O	SH
18. When I get frightened, my heart beats fast.	O	O	O	PN
19. I get shaky.	O	O	O	PN
20. I have nightmares about something bad happening to me.	O	O	O	SP

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	GD
22. When I get frightened, I sweat a lot.	O	O	O	PN
23. I am a worrier.	O	O	O	GD
24. I get really frightened for no reason at all.	O	O	O	PN
25. I am afraid to be alone in the house.	O	O	O	SP
26. It is hard for me to talk with people I don't know well.	O	O	O	SC
27. When I get frightened, I feel like I am choking.	O	O	O	PN
28. People tell me that I worry too much.	O	O	O	GD
29. I don't like to be away from my family.	O	O	O	SP
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. I worry that something bad might happen to my parents.	O	O	O	SP
32. I feel shy with people I don't know well.	O	O	O	SC
33. I worry about what is going to happen in the future.	O	O	O	GD
34. When I get frightened, I feel like throwing up.	O	O	O	PN
35. I worry about how well I do things.	O	O	O	GD
36. I am scared to go to school.	O	O	O	SH
37. I worry about things that have already happened.	O	O	O	GD
38. When I get frightened, I feel dizzy.	O	O	O	PN
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	SC
41. I am shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder.** Scores higher than 30 are more specific. TOTAL =

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. PN =

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder.** GD =

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC.** SP =

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder.** SC =

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance.** SH =

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: ____________________ Date: ____________________

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	O	O	O	PN
2. My child gets headaches when he/she am at school.	O	O	O	SH
3. My child doesn't like to be with people he/she does't know well.	O	O	O	SC
4. My child gets scared if he/she sleeps away from home.	O	O	O	SP
5. My child worries about other people liking him/her.	O	O	O	GD
6. When my child gets frightened, he/she fells like passing out.	O	O	O	PN
7. My child is nervous.	O	O	O	GD
8. My child follows me wherever I go.	O	O	O	SP
9. People tell me that my child looks nervous.	O	O	O	PN
10. My child feels nervous with people he/she doesn't know well.	O	O	O	SC
11. My child gets stomachaches at school.	O	O	O	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	PN
13. My child worries about sleeping alone.	O	O	O	SP
14. My child worries about being as good as other kids.	O	O	O	GD
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	PN
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	SP
17. My child worries about going to school.	O	O	O	SH
18. When my child gets frightened, his/her heart beats fast.	O	O	O	PN
19. He/she child gets shaky.	O	O	O	PN
20. My child has nightmares about something bad happening to him/her.	O	O	O	SP

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.	O	O	O	GD
22. When my child gets frightened, he/she sweats a lot.	O	O	O	PN
23. My child is a worrier.	O	O	O	GD
24. My child gets really frightened for no reason at all.	O	O	O	PN
25. My child is afraid to be alone in the house.	O	O	O	SP
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	SC
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	PN
28. People tell me that my child worries too much.	O	O	O	GD
29. My child doesn't like to be away from his/her family.	O	O	O	SP
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. My child worries that something bad might happen to his/her parents.	O	O	O	SP
32. My child feels shy with people he/she doesn't know well.	O	O	O	SC
33. My child worries about what is going to happen in the future.	O	O	O	GD
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	PN
35. My child worries about how well he/she does things.	O	O	O	GD
36. My child is scared to go to school.	O	O	O	SH
37. My child worries about things that have already happened.	O	O	O	GD
38. When my child gets frightened, he/she feels dizzy.	O	O	O	PN
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	O	O	O	SC
41. My child is shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

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A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

Patient Name: ______________________

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW THIS INFORMATION MAY BE ACCESSED

Your child's medical record may contain personal information about their health. This information may identify them and relate to their past, present, or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your child's PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your child's PHI.

How we may use and disclose health care information about your child:

For Care or Treatment: Your child's PHI may be used and disclosed to those who are involved in their care for the purpose of providing, coordinating, or managing medical services. ***Example:*** *If another physician referred your child to us, we may contact that physician to discuss your child's care.*

_________________________________ Patient (if over 18) or Representative __________ Date

Please check the following if applicable:

__ You may call my cell phone and leave a message on my answering machine if I am not available.

__You may discuss by electronic communication or phone, my child's symptoms (if pediatric patient), diagnosis and treatment with teachers and school representatives.

__I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my child's care or payment for my child's care.

Name: _________________________________Relationship: ___________________________________

Name: _______________________________ Relationship: ___________________________________

Check all that apply to names above:

- __ All my child's medical information
- __ Specific medical information such as test results, prescriptions
- __ Information necessary to help my family member(s) take care of my child.

____________________________________ Patient/Guardian Signature _________ Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize: ___________________________________ (practitioner) to release/disclose my child's health information as described below.

Practitioner's Name: ____________________________________
Address: __________________________________ (City) ___________ (State) ________ (Zip) ________
Office Phone: ____________________ Office Fax: _______________________

Please identify the information to be released: ____Please Release ALL Records ____Office Notes ____Testing Results ____Medication List

Please initial below to indicate your understanding:
____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Attention-MD NJ Financial Policy

This financial policy contains important information about payment for our professional services. Payment for professional services may be made by cash, check, or credit/debit card. *It is intended to help us provide your child with the highest level of medical care and help control administrative costs for services provided.* **Attention-MD New Jersey is a fee-for-service provider. Payment for provided services is expected at the time of service.**

At the time of service, the practice will provide an itemized receipt of payment for medical and testing services performed which can be submitted to your insurance company for reimbursement.

Attention-MD NJ will continue to work with insurance companies to help our patient's maximize pharmacy and laboratory benefits, to the best of our ability. We cannot guarantee insurance coverage for all recommended treatments, medications, or laboratory tests.

Our services may or may not be covered by your policy. It is **your** responsibility to contact your carrier to determine if our services are covered under your contract ***prior*** to the date of service Patients 18 years old and above, who are covered under the insurance policy of the parent or guardian, must designate whether responsibility for payment will fall upon the parent/ guardian or themselves.

The fees at Attention-MD New Jersey are as follows:

New Intakes with Doctor: $475: Evaluation includes in-person comprehensive medical and psychosocial history and clinical interview; review of submitted medical information and behavioral symptom forms; and objective neuropsychological testing (QbTest) with interpretation; and treatment recommendations. E/M codes: 99204, 96132. 96138, 96127

Follow-up Visits with Doctor: $135.00 Evaluation includes in-person review of interval medical and psychosocial history and clinical interview, with adjustment of treatment as necessary. E/M codes: 99214, 96127

Follow-up Visits with objective neuropsychological testing (QbTest): $220.00 Evaluation includes in-person review of interval medical and psychosocial history and clinical interview, with adjustment of treatment as necessary; and QbTest with interpretation. E/M codes: 99214, 96132, 96138, 96127

Telehealth encounter---$90.00 Limited to out-of-area college attending patients and patients experiencing a practice-recognized emergency or illness. Evaluation includes a video/audio review of interval medical and psychosocial history and clinical interview with adjustment of treatment as necessary. E/M codes: 99442, 96127

Additional Charges for Non-Medical Services –THESE CANNOT BE SUBMITTED TO INSURANCE

Late Cancellation/No Show Extended Appointment $150	Returned Check $35
No Show Follow-up Appointments $50	Form Completion Fee (Not at Time of Service) $10 per Issue
Accommodation Requests (Extensive) $50	Medical Records Copies ----- $10 Administrative fee plus $1 per page for pages 1-25 /$0.50 per page for pages 26 and over

I have read and understand the financial policy as stated.

______________________________________ Guarantor Print Name (Parent/Guardian/Patient)

__________________________ Patient (if over 18) or Guarantor Signature ________________ Date

LATE RESCHEDULING/CANCELLATION/NO SHOW POLICY

Our provider's time is reserved for you. We do not double book our patients in order to provide adequate time for each individual appointment. We strive for exceptional care through individual attention. **Any appointment rescheduled or cancelled *less 24 hours before the appointment day* is considered a Late Rescheduling/Cancellation/No Show.**

A Late Rescheduling/Cancellation/No Show on a new or extended patient appointment will result in a $150 fee that is not covered by insurance.

A Late Rescheduling/Cancellation/No Show on an established patient appointment will result in a fee of $50 that is not covered by insurance.

Repeated Late Rescheduling/Cancellation/No Show appointments will result in unconditional discharge from care at this facility.

I, ________________________________, (patient/parent/legal guardian) acknowledge that I fully understand the Attention-MD NJ Late Rescheduling/Cancellation/No Show policy.

________________________________ Signature Patient/Guarantor _______ Date

Patient Name: ______________________

Attention-MD NJ Credit/Debit Card Policy

We welcome you to our practice. We look forward to helping your child and you understand and manage the attention, learning and associated conditions that your child faces.
In order to reduce administrative costs, we will ask you for a credit/debit or health savings card which will securely be held on file and be used to process patient balances, charges for evaluations and testing, and non-covered services and fees, which are not paid for in another manner at the time of service. The Card will be used to process professional services, as well as administrative fees under the following circumstances. Any questions regarding our billing procedure can be addressed with our Practice Manager.

1. 1) All patient balances, not paid by 70 days following the date of professional service.
2. 2) All services, test, and office policy fees not otherwise paid within thirty (30) days of fee accrual including but not limited to, missed or late cancelled appointment fees.
3. 3) Failure to comply with the practices Financial Policy, in total will result in the following: a. No future appointments will be scheduled for the patient.
   b. Your account will be turned over to a collection agency.
   c. We will provide a summary copy of your medical records and ensure prescription for one (1) month supply of appropriate medication. (At the discretion of the medical services provider). We greatly appreciate your understanding and cooperation.

I, ___________________________(parent, legal guardian, patient if 18 or older), acknowledge that I understand the Attention-MD NJ, Credit/Debit card policy.

Card Type: ___________ Name on Card: ____________________________

Card Number: __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __

Expiration Date: ___________. CVV:________

Billing Address: _______________________________________ City:_____

_________________________________Guarantor Signature or Patient (if 18 or older) Date__________