Pediatric Neurology of Lehigh Valley
Boosara Ratanawongsa, M.D
961 Marcon Blvd. Suite #452
Allentown, PA 18109
(P) 610.398.9898
(F) 610.398.9899

DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

Name:____ Today's Date: ____
Last First M

Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W

GENDER: □MALE □FEMALE

SSN: ____DOB: ____

RACE: □African American/Black □White □American Indian/Alaska Native □Asian □Native Hawaiian or Pacific Islander □ Declined

ETHNICITY: □Hispanic □Non-Hispanic □Declined

PARENT #1 INFORMATION

Name:____ SSN: ______________________________DOB: __________________________
Last First M
Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W E-mail_____________________________________

Occupation: ____Employer____

Relationship with patient______________________________ Do you live with child? □NO □YES

PARENT #2 INFORMATION

Name:____ SSN: ______________________________DOB: __________________________
Last First M
Address: ____
Street Address City State Zip Code

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W E-mail_____________________________________

Occupation: ______________________________________ Employer____

Relationship with patient______________________________ Do you live with child? □NO □YES

EMERGENCY CONTACT #1

Name:____Relationship____

Phone #1(______)_______-________ □ H□C□W Phone #2(______)_______-________ □ H□C□W

EMERGENCY CONTACT #2

Name:____Relationship____

PHONE #1(______)_______-________ □ H□C□W PHONE #2(______)_______-________ □ H□C□W

REFERRAL INFORMATION

Referring physician name: ____ Phone:(____)______-_______ Fax:(____)_______-________

Address:____

Street Address City State Zip Code

PRIMARY CARE PHYSICIAN INFORMATION

PCP name: ____ Phone:(____)______-_______ Fax:(____)_______-________

Address:____

Street Address City State Zip Code

INSURANCE INFORMATION

____

PRIMARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER NAME____RELATIONSHIP____

____

SUBSCRIBER SSN DOB EMPLOYER WORK #

DO YOU HAVE A SECONDARY INSURANCE? □ NO □ YES. IF SO, PROVIDE INFORMATION BELOW

____

SECONDARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

POLICY HOLDER
NAME____RELATIONSHIP____

____

SUBSCRIBER SSN DOB EMPLOYER WORK #

PHARMACY INFORMATION

PREFERRED PHARMACY NAME____

ADDRESS____

PHONE (__________)_________-__________ FAX NUMBER (__________) _________-___________

The information I provided is correct to the best of my knowledge.

Parent/Guardian Signature____Date____

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CONSENT FOR TREATMENT

In presenting my child for diagnosis and treatment, I hereby voluntarily authorize Pediatric Neurology of Lehigh Valley, through its appropriate personnel, to perform or have performed upon me or my child, appropriate assessment and treatment procedures as may in the providers professional judgement be necessary. I further authorize Pediatric Neurology of Lehigh Valley, to release to appropriate agencies, any information acquired in the course of my child's examination and treatment.

I give my consent to the provider and staff of Pediatric Neurology of Lehigh Valley to perform medical services determined to be necessary or advisable for the benefit of my child's healthcare. Pediatric Neurology of Lehigh Valley is authorized to use and disclose my protected health information for treatment, payment, and operations consistent with its Notice of Privacy Practices.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

By signing below, I certify that I have read, reviewed carefully, and fully understand and accept the terms of treatment for me or my child provided by Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with all of our treatment practices.

______________________________ ____________
PATIENT NAME DOB

______________________________ ____________
GUARANTOR NAME (PRINTED) DOB

______________________________ ____________
PARENT/GUARANTOR SIGNATURE DATE

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FINANCIAL POLICY

Thank you for choosing Pediatric Neurology of Lehigh Valley to care for your child's neurological health care needs. If you may have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance. We look forward to the opportunity to provide you, your family, and your child with compassion and exceptional care. The following is a statement of our Financial Policy. Please read prior to your appointment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

All co-payments, co-insurance, and deductibles are due at the time of service, prior to seeing the provider. We accept cash, checks, Visa, Mastercard, Amex and Discover. Additionally, you will be asked for a credit card at the time you check-in. We will scan the card in our system, and the information will be held securely until your insurance has paid their portion and notified us any additional amount owed by you. At that time, you will receive a notification that the remaining balance owed will be charged to your credit card. Please note that there is a $35.00 fee for returned checks.

INFORMATION REGARDING INSURANCE

Contracted Insurance Plans: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays, deductibles and co-insurance percentages are due prior to treatment. Payment for the visit is your responsibility. It is also your responsibility to ensure that you obtain an insurance referral from your primary care physician if one is required. If you are treated without a referral, you will be responsible for the charges incurred. If we do not have the updated insurance information at the time of the appointment you will be responsible for the entire visit, and you must submit to your insurance company for reimbursement.

Non-Contracted Insurance Plans: We are not contracted with Medicare or any form of (MA) medical assistance and will not bill MA or Medicare. You are responsible for payment of all services rendered whether covered by insurance or not. For non-contracted commercial insurance plans, to assist you, we will bill your commercial insurance company. If we don't have your updated insurance information on file at the time of your visit, you will be responsible to pay all costs and you must submit to your insurance company for reimbursement. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Non-covered services: Please be aware that some – perhaps all – of the services or diagnoses you receive may be non-covered or not considered reasonable or necessary by your insurance company. This includes, in accordance with AMA CPT guidelines, we reserve the right to charge for telephone/video calls, after business hours/weekend appointments with Dr. Boo that include evaluation and management of your medical condition. We will bill your insurance for such charges, but if it is not covered by your plan, you will be responsible for the charges. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

OTHER FEES

Missed Appointments: We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours/1 full business day prior to canceling your appointment. Unless canceled at least 24 hours/ 1 full business day) in advance—i.e., by Friday morning for a Monday morning appointment, our policy is to charge for missed appointments at the rate of $125.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

Collections: You will be dismissed from the practice if you fail to meet your financial responsibilities within 60 days and/or we must use a collection agency to bring your account up to date.

Minor Patients: Please note that the adult accompanying the minor child to the appointment and the parents (or guardians of the minor) are responsible for full payment at the time of the visit.

Forms: There may be a minimal charge of $10.00 and up to a maximum of $50.00 for completion of any forms not completed during a scheduled office visit.

Right to Amend: You understand and agree that PNLV may amend the terms of this Financial Policy at any time without prior notification to the patient.
Please keep this policy for your records. Sign the following acknowledgment and return to the staff of PNLV to keep on file.

Assignment of Benefits: I hereby assign, transfer, and set over directly to Pediatric Neurology of Lehigh Valley (PNLV) sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize PNLV to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to PNLV, I authorize PNLV to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

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FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

By signing below, you are acknowledging that you have read, reviewed carefully, and fully understand our Financial Policy and accept your financial responsibility to Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with our financial practices. You understand that you are obligated to ensure payment of the fees stated in our Financial Policy, in full and in a timely manner.

Patient Name:_________________________________ DOB:_________________________________

Guarantor Name:______________________________ DOB:_________________________________

Parent/Guarantor Signature:______________________ DATE:________________________________

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how PNLV may use and disclose medical information about you or your child, and how you can obtain access to this information. Please review our policy carefully. If you may have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance. We look forward to the opportunity to provide you, your family, and your child with compassion and exceptional care.!

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of PNLV. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.!

ADDITIONAL USES OF INFORMATION

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. Please review those rights below.

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

PNLV DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office.

Violations: If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below you are acknowledging that you have read, reviewed carefully, and fully understand and accept the privacy practices of Pediatric Neurology of Lehigh Valley. You understand that if you at any point have questions or concerns regarding these policies, you
can refer to the Notice of Privacy Practices, or call our office.

Patient Name:____ DOB: __________________________________

Parent Name:____

Parent/Guardian Signature:_____________________________DATE:_________________________________

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INITIAL PATIENT INFORMATION QUESTIONNAIRE

Parents/ Guardians: Please help us provide the best possible care for your child by filling out this form.

Patient Name:______________________________________DOB:__________________
Last First M

Name of person completing form:____________________ Relationship to patient:___________
How did you hear about our office?____

Primary Physician: ______________________________ Phone: ___________________
Address: ____

Reason for today's consultation?

Main questions or concerns regarding your child?
1. ____
2. ____
3. ____

What are your expectations for this evaluation?____
____

Has your child seen another neurologist, developmental pediatrician or psychiatrist in the past for your current concern?
□No □Yes If so, please provide Name & Address.
____
____

Please indicate if your child is: □ Left Handed □Right Handed □Ambidextrous □No Preference

Current Medications (Feel free to attach a medication sheet if there is not enough space provided.)

Medication Name	Dose	How Often

Vitamins/ Supplements:
____
____

Drug Allergies/ Adverse Reactions (Please list drug and reaction):

___

___

Food/Seasonal Allergies

___ ___ ___ ___

Does you child have an allergy to Latex? □No □Yes

Immunizations: □ Up to date □ Up to date but given on delayed schedule □ Not up to date/ deferred
If not up to date, please explain: ___

Past Medical History
Please list known prior medical diagnoses below.

1. ___ 4. ___

2. ___ 5. ___

3. ___ 6. ___

Other:

Has your child ever had (Please check all that apply)

□ Seizures □ Meningitis/Encephalitis □ Head Injury/Concussion Explain ___

___ Has your child ever been hospitalized? □No □Yes. Explain. (Please include dates and reason)

___

___

Has your child ever had surgery? □No □Yes. Explain. (Please include dates and type)

___

___

Does your child experience hearing difficulties? □No □Yes. Explain. ___

Has your child ever had a formal hearing evaluation since newborn period? □No □ Yes. Explain. (Please include dates, where performed, and results) ___

Does your child experience vision difficulties? □No □Yes. Explain. ___

Has your child been seen by an eye specialist? □No □Yes. Results: ___

Does your child wear glasses or contact lenses? □No □Yes

Comments: ___

___

Has you child ever had neuroimaging (Brain MRI, Head CT, etc.)? □No □Yes. (Please include dates, where performed, and results)

Has you child ever had an EEG? □No □ Yes. (Please include dates, where performed, and results)

Birth History:

□ PLEASE CHECK if patient is ADOPTED. If so, can this be discussed in front of patient? □ Yes □ No

Did mother receive regular prenatal care? □No □Yes

Did mother have exposure to any of the following? □Drug Use □ Alcohol Use □ Cigarettes

If so, please describe the substance and extent of exposure

Non-prescription medication taken during pregnancy: ____________________________________

Prescription Medication taken during pregnancy:______________________________________

Birth Weight: _______Mother's Age at time of delivery: _______Father's Age at time of delivery: _______

How many weeks was the pregnancy: ________ What number pregnancy was your child: ________

What number live birth was your child: ________ Mode of Delivery: □ Vaginal □ Cesarean

Use of assistive devices (forceps or vacuum): □No □Yes. Explain.__________________________

Has mother had any (check all that apply): □ Miscarriages □ Stillbirths □ Terminations

If so, please provide any relevant medical reasons (genetic defect, ectopic pregnancy, etc.) ___________

____

Did mother have any health problems during this pregnancy? Check all that apply.

□Anemia □ Bleeding □Diabetes □Fever □Frequent Illness/Infection □Excessive Vomiting

□High Blood Pressure □Preeclampsia/Eclampsia/Toxemia □Surgery □Other _________________

Additional comments:

Were there any complications during labor or at the delivery? □ No □ Yes.
Explain.____

____

Did your child show any of the following signs of distress during or immediately after the birth?
□Poor Color □Not Breathing □Not Crying □Cord wrapped around neck □Poor APGAR Score

Did your child require any form of resuscitation at delivery? Check all that apply. □ Oxygen

□Medication □ Chest Compressions □ Other. Explain. ____________________________________

____

Did your child have any of the following medical difficulties in the newborn period? □Apnea or Bradycardia □Jaundice (□ Phototherapy) □ Seizures □Infections □Anemia (□Transfusion) □Low Blood Sugar □ Other. Explain.____

____

Was there a need for your child to be admitted to the NICU (neonatal intensive care unit) following the birth? □No □Yes. If so, please describe (Duration of stay, need for breathing support, feeding tube, etc.)

____

____

Additional comments:

Developmental History:

Has your child ever experienced any delayed verbal or motor milestones? □ No □ Yes

Has your child ever experienced any regression, or lost any motor or verbal skills they once possessed? □No □Yes

❖If you have no concerns regarding your child's development, then skip to Educational History❖

To the best of your knowledge, please indicate the age at which your child developed the following skills. If you cannot recall the exact age, indicate whether NL for normal, ADV for advanced, or D for delayed

Head Control		Pointed Purposefully	
Rolled Over		Said First Words	
Sat Alone		Used 2-Word Phrases	
Crawled		Used 3-Word Phrases	
Babbled (gaga, dada)		Identified Body Parts	
Pulled to Stand		Read	
Cruised Furniture		Wrote Name	
Walked Alone		Rode a Bike	

Is your child toilet trained? □No □Yes. If so, please indicate when.______________________________

Has your child had poor hand coordination? (i.e., trouble with buttoning, snaps, opening bottles, tying shoes) □No □Yes. Describe.____

____

Does your child have difficulty with overall body coordination? (i.e., learning how to kick or throw a ball, frequent falls) □No □Yes. Describe. ____

____

Is your child overly sensitive to any of the following stimuli? Check all that apply. □Light □Sound □Touch □Food Textures □Fabric/Clothing □ Other.____

Does your child exhibit any of the following sensory seeking behaviors? Check all that apply.

□Chewing on Clothing □Licking others □Biting without wish to harm others

□Need for deep pressure □Need for excessive contact □Other____________________________

Educational History:

Name of School:____________________________School District:______________________________

Current Grade in School:_____________________ Average Grades (ie., A, C):____________________

□Private □Public □Home School □Cyber School □Other__________________________________

Do you have concerns regarding your child having learning difficulties? □No □Yes

❖If you have no concerns regarding learning difficulty, then skip to Emotional/Behavioral History❖

Areas of academic strength: ____

Areas of academic difficulty:____

If your child has an Individualized Education Program (IEP) or 504 Accommodation Plan, please state the reason for this: ____

Has your child been diagnosed with a Learning Disability? □No □Yes. Describe:__________________

Is your child pulled out for learning support? □ No □ Yes. If so, for which subject (s)?________________
____Has your child ever had to repeat a grade □No □Yes. If so, which grade and why?__________________
Is you child currently receiving any of the following supports? (Check all that apply and indicate how often, where and when these are provided (school, privately)

□ Physical Therapy ____________________________ □ Speech Therapy ______________________
□ Occupational Therapy _________________________ □ Other________________________________

Emotional/Behavioral History:

Do you have any concerns regarding your child's emotions or behavior? □No □Yes.
Describe:____
____

❖ If you have no Emotional or Behavioral concerns, then skip to Sleep & Dietary History ❖

Do you have any concerns about managing your child's behavior? □No □Yes. Describe:_____________

Disciplinary Methods Tried	Efficacy of Disciplinary Method

Has your child ever seen a behavioral specialist, counselor, or psychiatrist? □No □Yes.
Explain.
____
Does your child exhibit any of the following behavioral concerns?
□ Temper Tantrums □ Aggression □ Oppositional/ Defiant Behavior □ Hyperactive
□ Impulsive □ Inattentive □ Other
Explain:
____
Does your child experience any of the following? Check all that apply.
□ Anxiety □ Sadness/ Depression □ Obsessive thoughts □ Compulsive behavior
□Fears/Phobias □ Other
Explain:

____
Has your child ever been given a prior Psychiatric Diagnosis: □No □Yes
Explain.

Has your child previously taken medication to manage mood, emotions, or behavior? □No □Yes
If so, please provide details below:

Medications	Dates	Response to Medications

Sleep History:

Does your child experience any of the following?

□ Trouble falling asleep □Intermittent awakening during the night □Trouble waking up in the morning

□ Excessive Tiredness during waking hours □Bedwetting □Need to co-sleep (with parent, sibling, etc.)

Sleep pattern may impact your child's health. Please describe your child's sleep pattern during a typical academic school year.

	WEEKDAYS	WEEKENDS
Time of Waking Up		
Time No Longer Tired in AM		
Time Getting Into Bed		
Time Actually Falling Asleep		
If tired during the day, at what times and for how long?		
If night time awakenings occur, please note suspected cause (snoring, urination), frequency & duration		

Does your child seem to have trouble catching his/her breath while sleeping? □No □Yes.
If your child snores, are you concerned that your child's snoring may disrupt his/her sleep? □No □Yes.
Has your child ever had a sleep study? □No □Yes. Results: __________________________________

Dietary History:

Does your child have any food restrictions or allergies? Explain.________________________________

____

Does your child follow a specialized diet? Explain.____

Social History:

Main language(s) spoken in the home:_______________

Parents/Other:

1. _______________

Name Relationship to Child Profession

2. _______________

Name Relationship to Child Profession

Marital status: □ Married □ Never Married □ Separated □Divorced

Other pertinent caregivers/ details:

If your child has siblings, please list their names and ages: _______________

____

Please list all individuals living in the home, indicating their relationship to your child. Please describe any important specifics you would like to share regarding living arrangements/custody issues.

____

____

____

Please list child's personal strengths: _______________

____

Please list child's favorite activities/interests: _______________

____

Family History:

Please indicate if any other family members have had any of the following:

Medical Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Cardiac/ Heart Disease					
Bleeding or Clotting Disorder Explain:					
Thyroid Disease					
Diabetes					
Cancer					
Stroke or Intracranial Bleed Explain:					

Neurological Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Delay in Speech					
Delay in Motor Skills					
Learning Disability					
Tic Disorder/Tourette					
Seizures/ Epilepsy					
Headaches/Migraines					
Attention Deficit /Hyperactivity					
Autism					
Intellectual Disability					
Neurological Regression/ Loss of Prior Skills					
Genetic/ Congenital Disorders					
Psychiatric Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Anxiety					
Depression					
Bipolar Disorder					
Obsessive Compulsive Disorder					
Schizophrenia/ Psychosis					

Other comments regarding family history:

Review of Symptoms: (Please circle any symptoms your child has exhibited over the **past week**)

System				
Constitutional	Weight loss/gain (circle which)	Fever	Fatigue	□ No current concerns Other:
Ophthalmologic	Visual changes	Eye pain	Blurred vision	□ No current concerns Other:
Ears, Nose, Mouth, Throat	Sore throat	Ear infection	Hearing difficulties	□ No current concerns Other:
Cardiovascular	Heart racing	Heart skipping beats	Chest pain	□ No current concerns Other:
Respiratory	Wheezing	Shortness of breath	Cough	□ No current concerns Other:
Gastrointestinal	Nausea/ vomiting	Constipation	Diarrhea	□ No current concerns Other:
Genitourinary	Bedwetting	Pain urinating	Urinary tract infection	□ No current concerns Other:
Musculoskeletal	Muscle pain	Joint pain	Joint swelling	□ No current concerns Other:
Integumentary/ Skin	Eczema	Rash	Itchy skin	□ No current concerns Other:
Neurological	Headache	Feeling faint	Tics	□ No current concerns Other:
Psychiatric	Sadness	Anxiety	Mood swings	□ No current concerns Other:
Endocrine	Excessive thirst	Excessive urination	Poor physical growth	□ No current concerns Other:
Hematologic/ Lymphatic	Lymph node swelling	Easy bleeding	Easy bruising	□ No current concerns Other:
Allergic/ Immunologic	Itchy eyes	Sneezing	Runny nose	□ No current concerns Other:

The information above is complete and accurate to the best of my knowledge.

Parent/ Guardian Signature Relationship Date

The information above has been reviewed and formally discussed in depth with the family.

Physician Signature Date

Rev. 12/31/18 br

ADHD Rating Scale-IV: Home Version

Child's Name:__________________________ **Sex:** ☐ **M** ☐ **F** **Age:**_________ **Grade:**_________

Completed by: ☐ Mother ☐ Father ☐ Guardian ☐ Grandparent

Circle the number that *best describes* your child's home behavior over the past 6 months.	Never or Rarely	Sometimes	Often	Very Often
1. Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Fidgets with hands or feet or squirms in seat.	0	1	2	3
3. Has difficulty sustaining attention in tasks or play activities.	0	1	2	3
4. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
5. Does not seem to listen when spoken to directly.	0	1	2	3
6. Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7. Does not follow through on instructions and fails to finish work.	0	1	2	3
8. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
9. Has difficulty organizing tasks and activities.	0	1	2	3
10. Is "on the go" or acts as if "driven by a motor."	0	1	2	3
11. Avoids tasks (eg, schoolwork, homework) that require sustained mental effort.	0	1	2	3
12. Talks excessively.	0	1	2	3
13. Loses things necessary for tasks or activities.	0	1	2	3
14. Blurts out answers before questions have been completed.	0	1	2	3
15. Is easily distracted.	0	1	2	3
16. Has difficulty awaiting turn.	0	1	2	3
17. Is forgetful in daily activities.	0	1	2	3
18. Interrupts or intrudes on others.	0	1	2	3

From *ADHD Rating Scale-IV: Checklists, Norms, and Clinical Interpretation.* ©1998, George J. DuPaul, Thomas J. Power, Arthur D. Anastopoulos, and Robert Reid. Reprinted with permission from The Guilford Press, New York.

How to score

A diagnosis of ADHD depends on the type and number of symptoms your child is having and how those symptoms are affecting him or her. This screening tool is scored by a healthcare provider and is used in the process of making a diagnosis. The tables on the back of this screening tool are for use by your child's healthcare provider. If you feel that your child may be showing signs of ADHD, please complete this questionnaire and share the results with your healthcare provider.

For office use only (for healthcare provider interpretation).

IA subscale raw score ____________________

HI subscale raw score ____________________

Total subscale raw score ____________________

IA percentile score ____________________

HI percentile score ____________________

Total percentile score ____________________

Vanderbilt ADHD Diagnostic Teacher Rating Scale

INSTRUCTIONS AND SCORING

Behaviors are counted if they are scored 2 (often) or 3 (very often).

Inattention	Requires six or more counted behaviors from questions 1–9 for indication of the predominantly inattentive subtype.
Hyperactivity/ impulsivity	Requires six or more counted behaviors from questions 10–18 for indication of the predominantly hyperactive/impulsive subtype.
Combined subtype	Requires six or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.
Oppositional defiant and conduct disorders	Requires three or more counted behaviors from questions 19–28.
Anxiety or depression symptoms	Requires three or more counted behaviors from questions 29–35.

The performance section is scored as indicating some impairment if a child scores 1 or 2 on at least one item.

FOR MORE INFORMATION CONTACT

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The scale is available at http://peds.mc.vanderbilt.edu/VCHWEB_1/rating~1.html.

REFERENCE FOR THE SCALE'S PSYCHOMETRIC PROPERTIES

Wolraich ML, Feurer ID, Hannah JN, et al. 1998. Obtaining systematic teacher reports of disruptive behavior disorders utilizing DSM-IV. *Journal of Abnormal Child Psychology* 26(2):141–152.

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Name: ______________________________ Grade: __________

Date of Birth: ________ Teacher: __________________ School: __________________

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

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = 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 instruction 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 sustaining 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 (e.g., butts into conversations or games)	0	1	2	3
19.	Loses temper	0	1	2	3

(continued on next page)

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often				
20. Actively defies or refuses to comply with adults' 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 (i.e., "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
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/her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

PERFORMANCE

	Problematic		Average		Above Average
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavioral Performance					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Child's Name: ____ Today's Date: ______________

Date of Birth: ____ Age: ______________________

Grade: ____

Circle the number on the scale that corresponds to how you would rate your child's behavior.

0 = Never 1 = Occasionally 2 = Often 3 = Very Often

1.	Does not pay attention to details or makes careless mistakes, for example homework	0	1	2	3
2.	Has difficulty attending 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 things	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 needed for tasks or activities (assignments, pencils, books)	0	1	2	3
8.	Is easily distracted by noises or other things	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 he is suppose to stay in his seat	0	1	2	3
12.	Runs about or climbs too much when he is suppose to stay seated	0	1	2	3
13.	Has difficulty playing or starting quiet games	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 bothers others when they are talking or playing games	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively disobeys or refuses to follow an adults' requests or rules	0	1	2	3
22.	Bothers people on purpose	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 bitter	0	1	2	3
26.	Is hateful and wants to get even	0	1	2	3
27.	Bullies, threatens, or scares others	0	1	2	3
28.	Starts physical fights	0	1	2	3

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Child's Name: ___________________________

29.	Lies to get out of trouble or to avoid jobs (i.e., "cons" others)	0	1	2	3
30.	Skips school without permission	0	1	2	3
31.	Is physically unkind to people	0	1	2	3
32.	Has stolen things that have value	0	1	2	3
33.	Destroys others' property on purpose	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 mean to animals	0	1	2	3
36.	Has set fires on purpose 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, nervous, or worried	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes	0	1	2	3
43.	Feels useless or inferior	0	1	2	3
44.	Blames self for problems, feels at fault	0	1	2	3
45.	Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46.	Is sad or unhappy	0	1	2	3
47.	Feels different and easily embarrassed	0	1	2	3

How is your child doing?

		Problem		Average	Above Average	
1.	Rate how your child is doing in school overall	1	2	3	4	5
	a. How is your child doing in reading?	1	2	3	4	5
	b. How is your child doing in writing?	1	2	3	4	5
	c. How is your child doing in math?	1	2	3	4	5
2.	How does your child get along with you?	1	2	3	4	5
3.	How does your child get along with brothers and sisters?	1	2	3	4	5
4.	How does your child get along with others his/her own age?	1	2	3	4	5
5.	How does your child do in activities such as games or team play?	1	2	3	4	5