Bracken Psychiatric Services
3200 Southern Dr. #107 Garland, TX 75043
PH: (972) 278-5385 Fax: (972) 692-8687
e-mail: admin@brackenmentalhealth.com www.brackenmentalhealth.com

CHILD REGISTRATION FORM

Please note that we require:

1. All social security numbers requested in the registration form.
2. A copy of the guardian valid Texas I.D.
3. A copy of the insurance card front and back.
4. Proof of guardianship if applicable.

Please fax, e-mail; mail or bring your registration form to our office. We require 1 week to process your **complete** information. **Make sure you call us** after 1 week to schedule your appointment.

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Child Registration Form

Patient Last Name	First Name	Middle Name	Nickname
Address (Street)	City	State	Zip
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Patient lives with ☐ Parents ☐ Relatives Other _____

Mother/Guardian Last Name	First Name	Middle Name	Maiden Name
Address (Street)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Bring Pt. to Appts? (check one) ☐ Yes ☐ No	Date of Birth	Age	Social Security #	Valid TX I.D.#
Employer Name	Employer Address		

Father/Guardian Last Name	First Name	Middle Name	Maiden Name
Address (Street)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Bring Pt. to Appts? (check one) ☐ Yes ☐ No	Date of Birth	Age	Social Security #	Valid TX I.D.#
Employer Name	Employer Address		

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Claims Mailing Address (Street)		Claims Mailing Address (Street)	
City	State / Zip	City	State / Zip
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street)		Subscriber Employer Address (Street)	
City	State / Zip	City	State / Zip

Signature of Parent, or Legal Guardian **Date**

Private Pay Agreement

Please complete the Private Pay Agreement if your child has Medicaid as a secondary insurance.

I understand that Bracken Psychiatric Services is accepting

patient name:_____ as a private pay patient for the period of 1 year from today's date and as such I will be responsible for paying at the time of services for any services and fees I receive. I understand that the provider will not file a claim to Medicaid for services provided to the patient.
I understand that I may receive services from another provider at no cost using my Medicaid but I am choosing to pay privately so that the patient may receive services at Bracken Psychiatric Services.

Patient Name:_____ DOB:_____

Guardian Name:_____

Guardian Signature:_____ 

Date: _____

Consent to Treat and Financial Responsibility

I hereby authorize employees and agents of **Bracken Psychiatric Services** to render psychiatric evaluations including: medication management, psychotherapy and all usual practices of psychiatry to the patient indicated below.
The duration of this consent is indefinite and continues until revoked in writing.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

I hereby authorize payment of medical benefits directly to **Bracken Psychiatric Services** and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process or complete the patient's medical insurance claim and/or medication prior authorization.
I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV") as well as mental health and psychiatric protected health information.

I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to **Bracken Psychiatric Services**. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of **Bracken Psychiatric Services**, if any.

The duration of this authorization is indefinite and continues until revoked in writing.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

What language do you feel most comfortable speaking with your doctor?

- ☐ English
- ☐ Spanish
- ☐ Other _____

Patient Privacy Directive

Patient Last Name: _____ First Name: _____

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please provide us with the phone number(s) that we or an automated service may leave messages regarding appointments:

_____ _____

Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or medication information:

_____ _____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

_____ _____

_____ _____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your/your child's treatments and/or medications.

_____ _____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your billing:

_____ _____

_____ _____

Please provide an email address that we may use to communicate protected health information.
(Employee email is subject to the conditions set forth by the employer and may not be private.)

Email: _____ Confirm Email: _____

Please provide us with the name and number of your emergency contact:

_____ _____

You must inform us in writing of any changes in your directives. I acknowledge that everything above is accurate.

_____ _____

Signature *Printed Name & Date*

I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices"

_____ _____

Signature *Printed Name & Date*

_____ _____

Relationship If Patient Representative *Physician Office Representative*

Continuity and Coordination of Care
Authorization and Release of Information

Communication between and among your **behavioral health care providers**, your **primary care physician** and/or your **pain management providers** is important for you to receive comprehensive and quality healthcare. We are requesting that you authorize and consent to the exchange of health information between your **health care providers** identified below.

_____ _____, _____

Patient First Name Print *Patient Last Name Print* *Patient DOB*

I authorize the **health care providers** identified below to exchange information related to my/child's physical and behavioral health evaluations and treatment plans:

Jill Bracken D.O. Bracken Psychiatric Services	**Phone #:** (972) 278-5385
Address: 3200 Southern Dr. #107 Garland, TX 75043	**Fax #:** (972) 692-8687
www.BrackenMentalHealth.com	admin@brackenmentalhealth.com

Primary Care Provider Name:	**Phone #:**
Address:	**Fax #:**

Pain Management Provider Name:	**Phone #:**
Address:	**Fax #:**

	Phone #:
Address:	**Fax #:**

I, the undersigned, understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke this authorization I must send a written request to:

Privacy Officer at Bracken Psychiatric Services 3200 Southern Dr. #107 Garland, TX 75043.

This authorization expires **twelve (12) months** from the date of signature.

This information is being disclosed on the condition that it not be re-disclosed except as authorized or permitted by applicable Federal or State laws, including the Federal Privacy Regulations. I understand that information disclosed pursuant to this authorization may, in some instances, no longer be protected by the Privacy Regulations. Re-disclosure may occur in situations such as if my provider's care is reviewed by a State or Federal agency, a court orders the disclosure of information, or if I sue my provider and my provider needs the information to defend himself/herself.

Please initial to authorize:

☐ I give my authorization to release to, obtain from, and discuss with the identified health care provider(s) the following information**:** Medical information**,** HIV status, Substance abuse information and Behavioral health information, excluding "psychotherapy notes" as defined by HIPAA.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____ _____ _____

Printed Name of Patient Guardian/Representative Signature of Patient Guardian/Representative Date

_____

Relation to Patient

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Financial Obligation Letter

Dear Patient:

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost-effective psychiatric care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan and our office.

Payment Guidelines:

- You must pay any copayments, coinsurance and/or deductibles at the time of service.
- We accept cash, checks, money orders and credit cards (MasterCard and Visa).
- We charge a $30.00 fee for all returned checks. (We accept cash, credit card, money order or cashier's check only as payment for returned checks and fees.)
- We will file your insurance carrier as a courtesy.
- ***If you receive payment from the insurance company, please forward the payment (and all other papers you received) to our office. Please do not send the payment back to the insurance company.***

When do you present your insurance card?

Please present your insurance card at EACH VISIT. If there has been a change in your insurance we require a minimum of 48 business hours notice of the change**. If you cannot provide us the change of information within 48 business hours of your next appointment we will see you as a self-pay and you will be charged the self-pay rate for that visit.** If you come in to your appointment with new insurance and have not submitted the information to us 48 hours prior, we consider it as your intention of not using your benefits for that visit and your willingness to pay the self-pay rate. Bringing your change of insurance information to the appointment without prior notice is considered your omission of using your benefits for that visit and expectation of paying the full self-pay rate at the time of the visit. The missed appointment fee will apply if there is a cancelation with less than 24 business hours notice. Please visit www.brackenmentalhealth.com for the change of insurance form. Once we are able to get the benefits and bill the insurance and the visit is paid we will promptly refund your self-payment.

What happens if the insurance company denies payment?

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

- You have not met your deductible for the calendar year.
- This type of psychiatric service is not covered. The insurance was not in effect at the time of service.
- You have other insurance which must be filed first.
- You have exceeded your maximum dollar/visit amount; and/or
- You did not have a referral number for your visit/service.

If your insurance denies your claim for any of the above or other reasons, our office cannot be responsible for the bill. It is your responsibility to pay the denied amounts in full.

What happens if my insurance is not active at the time of the appointment?

You are automatically a self-pay patient and all fees and charges will apply. If you are not eligible for your state insurance at the time of your visit and you do not intend to keep your appointment and pay the self-pay rate you must contact the office 24 business hours prior to your appointment to cancel.

We value you as a patient and are eager to serve you. Our first priority is to provide you with the best possible care,

If you would like to contact our office, you may call us at 972-278-5385.

Sincerely,
Bracken Psychiatric Services

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. Both Bracken Psychiatric Services and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company as applicable by state and/or federal law.

Patient Name (please print)

Signature of Parent, or Legal Guardian **Date**

Psychiatric and Controlled Substance Agreement
Missed Appointment Agreement

This is an agreement between you and the provider at Bracken Psychiatric Services
and is made in order for you to understand your personal responsibilities while you or your child are taking
one or more of the following prescriptions: benzodiazepine and/or antipsychotic, amphetamines, or stimulant medications.

Please read the agreement fully and ask any questions that you have prior to signing.

I understand that Bracken Psychiatric Services will be monitoring my or my child's use and response to this medication(s).
Additionally, my compliance with the following guidelines will be required:

1. I will need to have scheduled visits to this office to safely monitor my medication(s).
   The number of visits required will depend upon my progress.
2. I will be required to give a 48-business hour notice for medication refills.
3. I understand that I am responsible to notify my provider of any changes to my address and phone number.
4. If I or my child are experiencing any side effect(s) from medication(s), I will call the office immediately and notify of the specific symptoms being experienced. I understand that I may need to leave this information with the answering service if a staff member is not available to pick up in the office. I understand that if I do not provide enough information when my call is answered the first time I call, it may take longer to get a response from the doctor as someone will need to call me back for more details before the doctor can receive my message.
5. If I want to request a dosage change I will call the office to schedule an appointment.
6. I understand that I am responsible for taking my or giving my child's medication(s) as prescribed and I will not be provided new prescriptions before they are due. Exceptions may be made and would be on a case by case situation when deemed necessary.
7. I understand that I am responsible for safeguarding my or my child's supply (against theft, loss, unauthorized use by others, etc.) and will not receive early refills of my prescriptions.
8. I understand that controlled substance medication(s) is only part of my or my child's treatment. I know that there are other aspects of my or my child's treatment (for example, recommended counseling, various behavioral modification techniques or additional testing such as neuropsych, lab work, oral swab, and/or urine sample) that I or my child may be required to perform or participate in while I am taking a prescribed controlled substance. The decision as to whether the medication is providing sufficient therapeutic benefit to justify continued use is a medical determination that will be made only by my provider at B.P.S.
9. I will keep my or my child's appointments as scheduled. I will be respectful to all office staff persons. I will contact Bracken Psychiatric Services as soon as possible in the event I need to cancel or reschedule an appointment.
   If fail to show up at the time of a scheduled appointment it will be recorded in my chart as a "no show".
   If a behavioral appointment is missed or rescheduled at the last minute (less than 24-business hours);
   Bracken Psychiatric Services will make the necessary accommodations in the behavioral provider's schedule to get me or my child seen as soon as possible. If I am not able or willing to take the appointment time offered I understand that any delay in care is my choice and not that of the provider.
10. Beginning January 1st 2016 Bracken Psychiatric Services will allow 3 missed appointments per calendar year. A missed appointment is defined as (a.) appointment no show, (b.) arrival 15 minutes after follow up appointment time or (c.) appointment cancellation or rescheduling with less than 24 business hours' notice. Same day reschedules will not require a $75.00 missed appointment fee but will count against the 3 missed appointment per calendar year limit. After your 4th missed appointment in the calendar year, Bracken Psychiatric Services will notify you in writing that you or your child will be referred to another physician. Please contact us so that we may provide you or your child with medication to limit any interruption in care.
11. I agree to comply with the foregoing guidelines as a condition to the provision of services by the practice. I understand that any violation of the above guidelines or requirements may result in my or my child's controlled medication prescription not being refilled and my discharge from the practice.

Patient Name _____ Date of Birth _____

Printed Guardian or Representative Name_____

Signature of Guardian or Representative_____ Date_____

Relationship to Patient _____

Acknowledgment of Review of Notice of Privacy Practices

Patient Name: _____ **Date of Birth:** _____

Bracken Psychiatric Services policy guide and privacy practices are available on our website: www.brackenmentalhealth.com and in our office.

I hereby acknowledge that I have received a copy of Bracken Psychiatric Service's Notice of Privacy Practices.

I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Legal Representative Date

_____

Printed Name of Patient's Representative

Relationship to Patient (*if applicable*

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

E-Prescribing/Medication History Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides they physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that **Bracken Psychiatric Services** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____

Patient Name (please print)

_____ _____

Signature of Parent, or Legal Guardian **Date**

Child & Adolescent Patient History Questionnaire

Child's Name:
Nickname?
Date of Birth:

What are the concerns/symptoms you are seeking treatment for?
When did you first notice these concerns?
Additional Concerns:

Past Psychiatric History

Has your child ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

_____

_____

_____

Has your child ever seen a psychologist?_____

_____

_____

_____

Has your child ever seen a therapist?_____

_____

_____

_____

Has your child ever been hospitalized for psychiatric reasons? If so, where and when?

_____

_____

_____

_____

Please circle the behaviors below that pertain to your child.

Nervous	Hyperactive	Temper tantrums	Poor sleep
Short attention span	Cries easily	Behavior problems	Destroys property
Easily frustrated	Excessive fears	Motor tics	Bite nails
Pulls hair	Frequent headaches	Frequent stomachaches	Fatigue/easily tired
Harms self (ie. cutting)	Hurts others (hits, bites, kicks)	Overweight	Perfectionist
Shy	Does not follow rules	Worries a lot	Overly talkative
Low self esteem	Likes self	Withdrawn/sullen	Slow learner
Demands attention	Plays well with peers	Irritable	Trouble making friends
Prefers to play alone	Depressed/sad	Legal problems	Weird ideas/bizarre thoughts
Running away from home	Vision problems	Hearing problems	Speech problems
Sexually active	Alcohol use	Drug use	Tobacco use
Legal Problems	Head Injury		

Medications: Please list all medications or supplements taken by your child.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Past Medical History:

Primary Care Physician:
Clinic Name, Address, and Phone #:

Current Medical Diagnoses *i.e. asthma, diabetes, seizures, etc*	Treatment?
1.	
2.	
3.	
4.	

Previous Surgeries	Approximate Date	Location/Hospital
1.		
2.		
3.		

Previous Hospitalizations	Approximate Date	Location/Hospital
1.		
2.		
3.		

Medication Allergies:
Food Allergies:
Are Immunizations Up-to-Date?

Developmental History:
Pregnancy:

Mother's Age During Pregnancy:	Prenatal Care Began in Which Trimester? 1st 2nd 3rd
How many total pregnancies for mother?	Which pregnancy was this one?
Any complications during the pregnancy? *ie. pre-term labor, high blood pressure, gestational diabetes*	Maternal drug, alcohol, or tobacco use during pregnancy?

Labor and Delivery:

Due Date:	Birth Date:
Hospital:	City, State:
Vaginal or C-Section?	Forceps or Vacuum Assisted?
Anesthesia? Epidural, Spinal, General, IV, None	Length of Labor?
APGAR Scores?	Birth Weight?
Complications During Delivery?	

Neonatal History:

Was your baby in the NICU?	How long did your baby stay in the hospital?
Did your baby have any nursery complications? Jaundice? Feeding problems? Infections?	Did your baby require resuscitation or oxygen?

Milestones: Please provide the age (in months) when your child attained the following milestone.

Sit unassisted	Hand-knee crawl
Walk independently	Pedal a trike
Finger feed	Toilet trained
Use "mama/dada" only for parent	First word
Point to indicate needs/wants	Used 10-15 words
Used 50 words	Put two words together

Family/Social History:

Who lives in the child's home?_____

Does the child have a second home where they spend part of the week?_____

Are parents married/partnered/separated/divorced?_____

How long have parents been married (*if applicable*)?_____

Mother	**Father**
Name:	Name:
DOB:	DOB:
Education Level:	Education Level:
Occupation/Employment:	Occupation/Employment:
Medical History:	Medical History:
Psychiatric History:	Psychiatric History:

Step-Mother *(if applicable)*	**Step-Father** *(if applicable)*
Name:	Name:
DOB:	DOB:
Education Level:	Education Level:
Occupation/Employment:	Occupation/Employment:
Medical History:	Medical History:
Psychiatric History:	Psychiatric History:

Siblings					
Name	DOB & Age	Relationship *(full,1/2,step,etc)*	Grade	Medical Problems?	Psychiatric Problems?

Family History: Please indicate if there is a family history of the following conditions and who is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Educational History:

Current School:	County/School District:
Address:	Phone Number:
Grade:	Type of Class: *Regular, Inclusion, Self-Contained, etc?*
Does your child have an IEP or 504 Plan?	Is your child in Exceptional Student Education (ESE)?
Does your child receive Speech Therapy at school?	Exceptionalities: *SLD, Autism, OHI, etc?*
Does your child receive Occupational Therapy at school?	Does your child receive Physical Therapy at school?
Has your child ever been suspended from school?	Has your child ever been expelled from school?

Please list the previous schools that your child has attended:

Years	Grades	School Name	Type of Class	Any problems? *Suspensions, Expulsions, etc*

Legal History:

Arrest(s):	Date(s):

Substance Abuse History *please include age of first use and frequency if known***:**

Alcohol First Used: Frequency:	**Marijuana (weed)** First Used: Frequency:
Cocaine (crack, coke) First Used: Frequency:	**Tobacco** First Used: Frequency:
Opiates (heroin, pain killers, methadone) First Used: Frequency:	**Benzodiazepines (Xanax, Klonopin, Ativan, Valium)** First Used: Frequency:
MDMA (ecstasy) First Used: Frequency:	**LSD (acid, hallucinogens)** First Used: Frequency:
Over the Counter (cough syrup, triple C's, laxatives) First Used: Frequency:	**Bath Salts, Spice, K2** First Used: Frequency:
Amphetamines (speed, Adderall, Ritalin) First Used: Frequency:	**Inhalants (dusters, whip its)** First Used: Frequency:
Other: First Used: Frequency:	**Other:** First Used: Frequency:

Any other issues not yet addressed?

Past Psychiatric Medication

Anti Depressants	**Response (Good, Fair, Poor)**	**Antipsychotic**	**Response (Good, Fair, Poor)**
Amitriptyline (Elavil)		Olanzapine (Zyprexa)	
Bupropion (Wellbutrin)		Perphenazine (Trilafon)	
Citalopram (Celexa)		Pimozide (Orap)	
Clomipramine (Anafranil)		Quetiapine (Seroquel)	
Desipramine (Norpramin)		Risperidone (Risperdal)	
Doxepin (Sinequan)		Asenapine (Saphris)	
Escitalopram (Lexapro)		Thioridazine (Mellaril)	
Fluoxetine (Prozac)		Thiothixene (Navane)	
Fluvoxamine (Luvox)		Trifluperazine (Stelazine)	
Imipramine (Tofranil)			
Mitrazapine (Remeron)		**Mood Stabilizers**	
Nefazodone (Serzone)		Carbamazepine (Tegretol)	
Nortriptyline (Pamelor)		Gabapentin (Neurontin)	
Paroxetine (Paxil)		Lamotrigine (Lamictal)	
Phenelzine (Nardil)		Lithium (Lithobid, etc)	
Dexvenlafaxine (Pristiq)		Topiramate (Topamax)	
Sertraline (Zoloft)		Valproic Acid (Depakote, etc)	
Tranylcypromine (Parnate)			
Trazodone (Desyrel)		**ADHD Medications**	
Venlafaxine (Effexor)		Amphetemine salts (Adderall, etc)	
		Clonidine (Kapvay, Catapres)	
AntiAnxiety		Dexmethylphenidate (Focalin)	
Alprazolam (Xanax)		Guanfacine (Intuniv, Tenex)	
Buspirone (Buspar)		Methylphenidate (Ritalin, Concerta, Daytrana, etc)	
Chlordiazepoxide (Librium)		Strattera (Atomoxetine)	
Clonazepam (Klonopin)		Vyvanse (Lisdexamfetamine)	
Clorazepate (Tranxene)			
Diazepam (Valium)		**Miscellaneous**	
Flurazepam (Dalmane)		Thyroid (Synthroid, Cytomel)	
Hydroxyzine (Vistaril)		Dilantin (Phenytoin)	
Lorazepam (Ativan)		Propranolol (Inderal)	
Oxazepam (Serax)		Naltrexone (Revia)	
Temazepam (Restoril)		Benztropine (Cogentin)	
Triazolam (Halcion)		Trihexyphenidyl (Artane)	
Zolpidem (Ambien)		L-Dopa	
Antipsychotic			
Aripiprazade (Abilify)		**Other Medications**	
Fluphenazine (Prolixin)			
Haloperidol (Haldol)			
Lurasidone (Latuda)			

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

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

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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: _____

American Academy of Pediatrics

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