2000 E 15 ST BLDG 150 STE A
EDMOND OKLAHOMA 73013

PHONE 405 348 6500 | FAX 405 348 6501

WEB JONROTHMD.COM

PATIENT DEMOGRAPHICS

SECTION 1: PATIENT INFORMATION

DATE:__________

NAME:______________________________ PREFER TO BE CALLED:________________

DATE OF BIRTH:________________ NAME OF SCHOOL:____________________________

CITY/STATE:____

SECTION 2: RESPONSIBLE PARTY

NAME:______________________________ RELATIONSHIP TO PATIENT:________________

ADDRESS:____

CITY:____________________ STATE:________________ ZIP:__________

PHONE: (___)____________ CELL PHONE: (___)____________ WORK PHONE: (___)____________

EMAIL:____

EMPLOYER:____

SECTION 3: PHYSICIAN INFORMATION

NAME OF PHYSICIAN:______________________________ PHONE: (___)____________

SECTION 4: WHOM MAY WE THANK FOR REFERRING YOU?

NAME:____

ADDRESS:____

PHONE: (___)____________

SECTION 5: APPOINTMENT REMINDERS BY

TELEPHONE (CIRLCLE ONE): HOME / CELL | Y | N |

TEXT: | Y | N |

EMAIL: | Y | N |

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FINANCIAL POLICY

I hereby authorize the above named doctor or clinic to furnish information concerning my present illness or injury and direct to the insurer to pay, without equivocation to the above named doctor or clinic, any and all benefits due them as a result of this claim. I am also aware that I am personally responsible for charges and/or balance not covered by my insurance. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

SIGNED:______________________________ DATE:________________

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PRIVACY POLICY / CONFIDENTIALITY NOTICE

I, ______________________________ have received a copy of the Privacy and Confidentiality Notice, and it has been explained to me.

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: ____________

I, ______________________________ give my permission to the following individual(s) to receive medical information and discuss the care of my child/children ______________________________ with Dr. Roth's office and staff.

These individual(s) may have access to my child/children's health information:

____

____

____

____

____

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: ____________

DR JON ROTH MD

2000 E 15 ST BLDG 150 STE A
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OFFICE POLICY

I would like to personally thank you for choosing me to participate in your child's care and to update you on my office's policies and procedures. These policies, procdures, office hours and price increases are effective May 1, 2013.

We are now accepting various Insurances, Please present your insurance card and co-pay on the day of the appointment and we will gladly file with your insurance company.

Office Hours: Our office hours are 9:00 am — 4:00 pm Monday, Tuesday, and Thursday and 9:00 am — 12:00 pm Wednesday, Friday, and Saturday.

Late appointments: If you are going to be 15 minutes or more late, you will need to call and reschedule the appointment if you show up and are more than 15 minutes late, your appointment may be rescheduled as there are appointments scheduled after you.

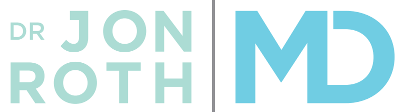
Initial Consultation: The initial consultation fee is $300. At this appointment, we will explore educational, family and psychological issues. The following current and past information will be obtained to assure a thorough initial evaluation; which may take up to a full hour. Birth and Developmental history, Educational history, Social/Behavioral History, Medical/Surgical history, Family history, Detailed review of systems, and brief physical examination. Please present your insurance card and co-pay on the day of the initial evaluation and we will gladly file with your insurance.

Follow-Up visits: You can expect up to three follow up visits after the initial evaluation, possibly more depending on your child's special needs. The fees for such visits are $170 and you can expect to be in the office for forty minutes. Please call the office at least 24 hours in advance if you cannot make your appointment or if a rescheduling is needed.

Prescription Refills: After a refill is requested, your prescription may either be mailed or picked up here at the office. Please try to inform us of a refill need before the remaining pills are completely diminished. We are now requiring that if an increase and/or change of medications are needed, or it has been more than three months, a follow up appointment is necessary to complete this transaction. **For those of you that have Strattera, Intuniv, Clonidine, Zoloft, Risperidone, Seroquel, Kapvay or Lexapro as medications, please call your pharmacy and have them send you a free refill request.**

Phone calls: please feel free to call the office a 405-384-6500 for follow up appointments, medication, refills, medication updates, etc. Any messages left on the phone during and after business hours will be returned in the way they were received.

Insurance: Our office is now accepting insurance. If your insurance requires an authorization/referral it is your responsibility to contact your primary care physician and obtain one, you could have it faxed to 405-348-6501 or 888-315-5146. If your insurance charges, it is your responsibility to contact our office with the changes. See the following list of insurance companies that we do/don't take.



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INSURANCE LISTING

As of April 1, 2011 this is the list of Insurance companies we accept and do not accept. The highlighted ones will be considered OUT OF NETWORK if they are listed anywhere on your insurance card. If you are considered OUT OF TOWN , the following office visits are as possible.

Insurance Companies - Approved

Aetna
Blue Advantage
Blue Cross, Blue Shield
Blue Lincs HMO
Cigna
Coventry Health and life
First Health
First Health Network
FMH Benefits - approved through Oklahoma Health Network and First Health Network
GEHA (Government Employees Hospital Association) thru United Healthcare
Great West Healthcare
Guardian (Multiplan)
Healthchoice
Kempton Company - approved thru Oklahoma health Network and First Health Network
Mailhandlers
Medicaid
Mercy Health Systems - approved thru Oklahoma Health Network and First Health Network
Mutual Assurance Administrators - approved thru First Health Network
Oklahoma Health Network
Pacificare PPO
Pacificaire HMO - (referral from PCP required before treatment)
Principal - approved thru Oklahoma Health Network and First Health Network
Tricare Prime
Tricare Standard
United Healthcare
Waterstone Benefit Administrators - approved thru Oklahoma health Network and First Health Network

Insurance Companies- out of network

Community Care HMO
Preferred Community Choice
PCC Select
PCC Select+

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IMPORTANT NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY.**

NOTICE OF PRIVACY POLICY

Effective January 2010

The following is the privacy policy of the office of Jon Roth MD as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPPA. HIPPA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal information. We are required by law to abide by the terms of this Privacy Notice.

YOUR PERSONAL HEALTH INFORMATION

We collect personal health information from you through treatment, payment, and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded that is created or received by certain healthcare entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

USES OR DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your health information within and among our workforce in order to accomplish these purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment of activities include: (a) the provisions, coordination, or management of health care and related services by healthcare providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or Insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agent, determinations of eligibility of coverage, adjudication or subrogation of health benefit claims: (c) medical necessity and appropriateness of care reviews, utilization review activities and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include: (a) development of clinical guidelines: (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination: (c) reviewing the qualifications of and training health care professionals: (d) underwriting and premium rating: (e) medical review, legal services, and auditing functions: and (f) general administrative activities such as customer service and data analysis.

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IMPORTANT NOTICE

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples: instances in which we are required to disclose your personal health information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or State law: (b) disclosures regarding victims of abuse, neglect or domestic violence including reporting to social service or protective services agencies: (c) health oversight activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit program: (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or lawful process: (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting death: (f) disclosures about descendents for purposes of caverdic donation or organs, eyes, or tissue: (g) for research purposes under certain conditions: (h) to avert a serious threat to health or safety: (i) military and veteran activities: (j) national security and intelligence activities, protective services of the president and others: (k) medical suitability determination by entities that are components of the Department of State: (l) correctional institutions and other law enforcement custodial situations: (m) covered entities that are government programs providing public benefits, and for workers compensation.

All Other Situations With Your Specific Authorizations

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be a sponsor of the plan.

YOUR RIGHT WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION

Under HIPPA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: (a) to carry out treatment, payment, and healthcare operations: (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death: (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance: (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information: or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

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IMPORTANT NOTICE

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communication

You have the right to receive confidential communication of your personal health information. We may require written requests. We may condition the provision of confidential communication on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information compiled is reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access had been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and the other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with written denial stating

IMPORTANT NOTICE

the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foresee ably rely, on such information to your detriment. All requests for amendment shall be sent to Jon Roth, 2000 E 15th Street, Building 150, Suite A, Edmond, OK 73013.

Right To Receive An Accounting Of Disclosures Of Your Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately proceeding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within the same twelve (2) month period. All requests for an accounting shall be sent to **Jon Roth MD, 2000 E 15th Street, Building 150, Suite A, Edmond, OK 73013.**

COMPLAINTS

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to **JonRoth MD, 2000 E 15th Street, Building 150, Suite A, Edmond, OK 73013.** A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPPA or this Privacy Policy. A complaint must be received by us or files with the Secretary of DHHS within 180 days of when you knew or should have known that the actor omission complained of occurred. You will not be retaliated against for filing any complaint.

AMENDMENTS TO THIS PRIVACY POLICY

We reserve the right to revise or amend the Privacy Policy at any time. The revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to the Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

ON-GOING ACCESS TO PRIVACY POLICY

We will provide you with a copy of the most recent version of the Privacy Policy at any time upon your written request sent to **Jon Roth MD, 2000 E 15th Street, Building 150, Suite A, Edmond, OK, 405-348-6500, or info@jonrothmd.com.** For any other requests or for further information regarding privacy or your personal health information, and for information regarding the filing of a complaint with us, please contact, please contact Jon Roth MD at the address, telephone number, or email address listed above.

Initial ADHD Evaluation Parent Questionnaire
(BLACK INK ONLY PLEASE)

Date: ______________________________

Name: ______________________________ DOB: ____________________ MRN: _________________

Teacher: ______________________________ Subject: ______________________________

I. EDUCATION HISTORY This section to be completed by Parents

School______________________________Current Grade________________

Primary Teacher______________________________Total # of Teachers______________________

What grade did school problems start?______________________________

Is your child currently receiving additional help? SSD________________ Other______________________________

Has your child had educational testing? No____ Yes____ If yes, by whom?______________________________

Results of testing______________________________

Other problems______________________________

____

Areas of concern:

___absenteeism	___peer relations	___memory	___written expression	___classwork completion
___anger control	___risk taking	___motor skills	___attention	___homework
___disobedience	___self esteem	___reading	___distractibility	___health problems
___disruptive behavior	___unhappy @ school	___receptive language	___hyperactivity	___inconsistent performance
___immaturity	___expressive language	___retaining information		___test taking
___motivation	___math	___spelling		

Comments on items ______________________________

____

____

II. PAST MEDICAL HISTORY / REVIEW OF SYSTEMS This section to be completed by Parents

	Y	N
1. Does the patient have any ongoing medical problems?	☐	☐
2. Do you have concerns about diet, sleep, exercise?	☐	☐
3. Has the patient had any of the following conditions: surgical procedures, significant allergies or allergic reactions to medications, head injury, seizures, facial tics or other repeated body movements, meningitis encephalitis or poisoning of any type?	☐	☐
4. Has the patient had any of the following problems: bed wetting, stool soiling, temper outbursts, mood changes, anxiety, depression, getting along with peers, lying, stealing, fire setting, destructiveness, cruelty to animals or self injury?	☐	☐
5. Did the mother have any medical problems during pregnancy, labor, delivery or post delivery period?	☐	☐
6. Did the patient have difficulty breathing or crying after delivery, have poor color, poor suck, slow growth and development?	☐	☐
7. Is the patient taking any medication at present? If yes, list medications:	☐	☐
8. Has your child been evaluated by an MD or mental health professional in the past for school or attentional problems?	☐	☐

If Yes to any of the above please comment______________________________

____

____

Initial ADHD Evaluation Parent Questionnaire
(BLACK INK ONLY PLEASE)

Date: ______________________________

Name: ______________________________ DOB: ____________________ MRN: _________________

Teacher: ______________________________ Subject: ______________________________

III. SOCIAL / FAMILY HISTORY This section to be completed by Parents

Mother's name______________________________Father's name______________________________

Occupation______________________________Occupation______________________________

Parents: Married________ Divorced________ Separated________

Patient lives with:______________________________

Siblings – names and ages:______________________________

____

Is there a family history of Attention Deficit Disorder, depression or substance abuse? Yes ☐ No ☐

If Yes please comment______________________________

____

____

IV. VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE This section to be completed by Parents

Please circle the frequency code which best describes your child in the context of what is appropriate for his/her age.

Frequency Code: 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 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 thing 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 when 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/play activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3

Initial ADHD Evaluation Parent Questionnaire
(BLACK INK ONLY PLEASE)

Date: ______________________________

Name: ____ DOB: ____________________ MRN: _________________

Teacher: ____ Subject: ____

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 intrudes on others (e.g., butts into conversations or games)	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 comply 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 vindictive	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Initiates physical fights	0	1	2	3
29. Lies to obtain goods for favors or to avoid obligations (i.e…."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 items of nontrivial value	0	1	2	3
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/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

Initial ADHD Evaluation Parent Questionnaire
(BLACK INK ONLY PLEASE)

Date: ______________________________

Name: ____ DOB: ____________________ MRN: _________________

Teacher: ____ Subject: ____

PERFORMANCE

	Problematic		Average	Above Average	
1. Overall Academic Performance	1	2	3	4	5
a. Reading	1	2	3	4	5
b. Mathematics	1	2	3	4	5
c. Written Expression	1	2	3	4	5
2. Overall Classroom Performance	1	2	3	4	5
a. Relationship with Peers	1	2	3	4	5
b. Following Directions/Rules	1	2	3	4	5
c. Disrupting Class	1	2	3	4	5
d. Assignment Completion	1	2	3	4	5
e. Organizational Skills	1	2	3	4	5

Please include any observations you feel are pertinent:____

____

____

____

Return form to your pediatrician when complete.

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

Mark Wolraich, M.D.
Shaun Walters Endowed Professor of Developmental and Behavioral Pediatrics
Oklahoma University Health Sciences Center
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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