Vanderbilt Assessment Follow up – Parent Informant

Date: ______________ Child's Name: ______________________________ DOB: __________

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. Please think about your child's behaviors in the past ______________ when rating his/her behaviors.
Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
2. Has difficulty playing or beginning quiet play activities	0	1	2	3
3. Fidgets with hands or feet or squirms in seat	0	1	2	3
4. Leaves seat when remaining seated is expected	0	1	2	3
5 Runs about or climbs too much when remaining seated is expected	0	1	2	3
6 Talks too much	0	1	2	3
7 Blurts out answers before questions have been completed	0	1	2	3
8 Has difficulty waiting his or her turn	0	1	2	3
9 Interrupts or intrudes on others' conversations and/or activities	0	1	2	3
10. Avoids, dislikes or does not want to start tasks that require ongoing mental effort	0	1	2	3
11. Has difficulty organizing tasks and activities	0	1	2	3
12. Has difficulty keeping attention to what needs to be done	0	1	2	3
13. Does not seem to listen when spoken to directly	0	1	2	3
14. Is easily distracted by noises or other stimuli	0	1	2	3
15. Is forgetful in daily activities	0	1	2	3
16. Loses things necessary for tasks or activities (toys, pencils, assignments or books)	0	1	2	3
17. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
18. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (teams)	1	2	3	4	5

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite – explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon or evening – explain below				
Socially withdrawn – decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking – explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing – explain below				
Sees or hear things that aren't there				

Explain/Comments:

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Total Symptom Score for questions 1-18: ____________________

Average Performance Score for questions 19-26: ____________________

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