Institute on Development and Disability (IDD)

Child Development and Rehabilitation Center

tel 503-418-2200
877-346-0640
fax 503-494-4447

cdrcnorthunit@ohsu.edu

Mail code: CDRC
PO Box 574
Portland, OR 97207-0574

Dear Parent or Guardian:

Welcome to the Autism Program at the Child Development and Rehabilitation Center and the Oregon Health & Science University Doernbecher Children's Hospital. We are honored that you chose us to care for your child. Our goal is to provide the highest quality care in a timely and respectful manner.

On the following page, we have provided you with a list of items you will need to obtain to help us with your child's evaluation.

We need you to return all the required documents before we can place your child on a waiting list for an appointment. Please either mail, fax or email the documents to our office as soon as possible to:

Oregon Health & Science University
Attention: CDRC
PO Box 574
Portland OR 97207-0574
Fax: 503 494-4447
email: cdrcnorthunit@ohsu.edu

If you need help collecting the information, please contact your referring provider's office, special education coordinators or case manager.

Please contact our staff if you have any questions at (503) 418-2200.

Please use black ink on all forms, make a copy of anything you send in the mail, and always keep your originals.

Thank you for your time and effort in completing and returning the packet. We look forward to working with you and your family.

Autism Program
Child Development and Rehabilitation Center
Institute on Development and Disability

Autism Program Intake Packet

The following items are needed from you before we can place you on the wait list for an appointment. If you have any questions, please call 503 418-2200.

Please make a copy of anything you send in the mail, and always keep originals. Please complete all forms in BLACK ink.

Institute on Development and Disability (IDD)

Child Development and Rehabilitation Center

Autism Program

tel 503 418-2200
877-346-0640
fax 503 494-4447

cdrcnorthunit@ohsu.edu
www.ohsu.edu/autism

Mail code: CDRC
PO Box 574
Portland, OR 97207-0574

Referral:

- ☐ Referral for evaluation from your child's primary care physician; (if one has not already been sent to us.)

Items for you to complete:

- ☐ OHSU Child Development and Rehabilitation Center, Patient Medical History
- ☐ NICHQ Vanderbilt Assessment Scale, Parent Informant
- ☐ Call patient registration at 503 494-8505 to set up or update the patient's account with OHSU. Please have insurance information ready when you call.

Items to obtain from school:

- ☐ Brief Teacher Questionnaire, Teacher Report Form (green), and, NICHQ Vanderbilt Assessment Scale, Teacher Informant. These are to be completed by a teacher, a preschool teacher or an Early Intervention therapist or home visitor.
- ☐ Copy of Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), or 504 Plan, if your child has one.
- ☐ Copy of most recent full individualized evaluation or special education eligibility testing, if your child is on an IEP or an IFSP.

Items to obtain from health providers:

- ☐ Copy of any prior diagnostic evaluations related to learning, language, motor skills, or psychological functioning, if applicable
- ☐ Copy of recent progress notes from current therapists, if applicable

Send packet by mail, email, or fax to:

Intake Coordinator, CDRC Autism Program
PO Box 574
Portland OR 97207-0574
Fax: 503 494-4447
cdrcnorthunit@ohsu.edu

DOERNBECHER CHILDREN'S *Hospital*

OHSU Child Development and Rehabilitation Center
Patient Medical History

Patient name: _____

Date of birth: _____

Please complete for each page

Please fill out this form as fully as you can. Use more paper if needed.

Your name: _____ Today's Date: _____

Relationship to child: _____ Who is child's legal guardian? _____

What name does your child like to be called? _____

1. What are you most concerned about?

2. When did these concerns begin?

3. What tests or treatments has your child had for these concerns?

4. What has been tried (including medicines) to help?

5. What are your child's strengths?

6. What are your goals for this visit?

Current medications, diet, other health care needs

List all medications (both from the doctor or over-the-counter) that your child is taking now.
(Use more paper if needed)

Does child take a multivitamin? ☐ Yes ☐ No Does child take fluoride? ☐ Yes ☐ No

Is child on a special diet? (explain)

Other health care needs (tracheostomy care, g-tube care, colostomy, etc.):

Has child had vision tested in the past year: ☐ Yes ☐ No Results: ☐ Passed ☐ Failed (explain)

Has child had hearing tested in the past year: ☐ Yes ☐ No Results: ☐ Passed ☐ Failed (explain)

Immunizations up-to-date? ☐ Yes ☐ No ☐ Don't know

Allergies (Please list): ☐ Medications ☐ Foods ☐ Other

Patient name: _____

Date of birth: _____

Please complete for each page

Pregnancy and birth history

Mother's age at baby's birth: _____

How many times has mother been pregnant? _____
Which pregnancy is this child? _____

Any miscarriages or terminated pregnancies?
☐ Yes ☐ No ☐ Don't know

Prenatal care started during _____ month of pregnancy

During pregnancy did the mother have:	Yes	No	Don't know
RH negative blood			
Diabetes			
High blood pressure			
Toxemia of pregnancy			
Vaginal bleeding or spotting			
Kidney or bladder infection			
Labor pains, cramping other than delivery			
High fever / flu-like illness			
Vaginal infection			
Membranes ruptured more than 24 hours before delivery			
☐ Too much or ☐ too little amniotic fluid			
Mother used prescription medications: (explain)			
Mother smoked cigarettes			
Mother drank alcohol			
Mother used recreational/street drugs: (explain)			
Mother experienced significant stress or emotional trauma			
Other serious illness / complications during pregnancy (explain):			

Delivery	Yes	No	Don't know
Induced labor			
Duration of hard labor: _____ hours			
☐ Forceps used or ☐ vacuum extraction			
Baby born breech or feet first			
Delivery by Caesarean section			
Difficult to get baby to breathe			
Twins or multiple births			
☐ Baby was early; weeks premature: _____ ☐ Baby was late; weeks postmature :_____			
Birthweight: _____ Length: _____			
Apgar score (if known): 1 minute: _____ 5 minutes: _____			
Other complications: (explain)			

After delivery baby had:	Yes	No	Don't know
Serious breathing difficulty			
Infections			
Jaundice			
I.V. or tube feedings			
Difficulty establishing feeding			
Seizures or convulsions			
Birth anomaly / anomalies (explain):			
Required a stay in Intensive Care Unit			
Baby discharged home at _____ days old			
Other concerns: (explain)			

Patient name: _____

Date of birth: _____

Please complete for each page

In first six months of life:	Yes	No	Don't know
Baby was difficult to feed			
Baby gained weight poorly			
Baby seemed too sleepy or too tired to eat			
Baby seemed "floppy" or was said to have low tone			
Baby had a lot of vomiting or excess spit up			
Baby had seizures			
Other serious illnesses/complications (explain):			

Review of systems (all ages)

Eyes, ears, nose, mouth, throat	Yes	No	Don't know
Vision or eye concerns			
Wears glasses			
Lazy eye or eye muscle difficulty			
Concerns with hearing			
Has hearing aid or cochlear implant			
Frequent ear infections			
Dental concerns			
Trouble chewing or swallowing			
Choking or gagging while feeding			
Frequent sore throats or tonsillitis			
Other concerns (explain):			

Skin	Yes	No	Don't know
Eczema or hives			
Other skin condition (explain):			

Cardio-respiratory (heart/lungs)	Yes	No	Don't know
Hayfever or asthma			
Chronic cough			
Trouble breathing			
Pneumonia			
Heart murmur or congenital heart defect			
High blood pressure			
Other concerns (explain):			

Abdominal region (stomach/intestines)	Yes	No	Don't know
Abdominal pain			
Poor appetite (picky eater)			
Spitting up frequently after eating			
Spells of vomiting			
Frequent constipation			
Frequent diarrhea			
Eating non-food items (dirt, paint)			
Hepatitis or jaundice after 1 month of age			
Other concerns (explain):			

Patient name: _____

Date of birth: _____

Please complete for each page

Genitals/urinary tract	Yes	No	Don't know
Bed wetting			
Abnormalities of the: ☐ penis/testicles ☐ vagina/female genitals			
Urinary tract or kidney infection			
Difficulty with urination			
Daytime urinary accidents			
For girls, has menstruation begun			
For girls, difficulties with menstruation (explain):			
Other concerns: (explain):			

Muscles and bone structure	Yes	No	Don't know
Hip dysplasia or dislocation			
Foot or leg deformity			
Scoliosis or other back deformity			
Recurrent leg or back pain			
Fractures (explain):			
Slow to walk, or delayed in motor skills			
Patient stumbles and falls frequently			
Frequent muscle cramps			
Other concerns (explain):			

Nervous system	Yes	No	Don't know
Frequent headaches			
Convulsions or seizures			
Staring spells			
Muscle tics, uncontrollable twitches			

	Yes	No	Don't know
Serious head injury or unconsciousness (explain):			
Other concerns (explain):			

Hospitalizations	
Reason for hospitalization:	Date:
Reason for hospitalization:	Date:
Reason for hospitalization:	Date:

Surgical procedures	
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

Please describe other medical evaluations the patient has had (e.g., neurology, MRI, EEG, genetics, gastroenterology, etc.)	
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

DOERNBECHER CHILDREN'S *Hospital*

OHSU

OHSU Child Development and Rehabilitation Center
Patient Medical History

Patient name: _____

Date of birth: _____

Please complete for each page

Development (Age Obtained)	Years	Months	Don't Know
Rolled over			
Was able to sit without support			
Learned to crawl			
Walked independently			
Learned to climb stairs			
Learned to ride tricycle			
Learned to ride bicycle			
Started to babble (sounds like "baba" or "dada")			
Played games like "peek a boo," "pat a cake"			
Pointed to indicate wants			
Used first words other than "mama" and "dada"			
Used 2-3 word phrases			
Used sentences			
Told stories/related events			
Toilet trained during day			
Became dry at night			

Speech and language	Yes	No	Don't know
Delays in speech (sounds) / language (words)			
Voice sounds differently from other children			
Saying sounds incorrectly			
Family not understanding speech			
Others not understanding speech			
Are other languages spoken at home?			
If other languages spoken at home, which does the child understand most? _____ Speak the most? _____			

Activities of daily living	Yes	No	Don't know
Able to drink from cup without spilling			
Able to use spoon without spilling			
Puts on shirt and pants without help			
Uses toilet without help			
Takes bath or shower without help			

Behavior	Yes	No	Don't know
Child is often irritable			
Child has frequent tantrums			
Child is too active			
Child is immature, acts like a younger child			
Child does not play well with others			
Child has unusual sensitivities to sounds, textures, touch, foods			
Child seeks out things to touch, has excessive or unusual movement, puts objects in mouth or eats non-food items			
Other concerns: (explain):			

Sleep	Yes	No	Don't know
Loud snoring			
Long breathing pauses during sleep			
Difficulty falling asleep			
Nightime waking/trouble staying asleep			
Nightmares/night terrors			
Other concerns: (explain):			

Patient name: _____

Date of birth: _____

Please complete for each page

Family/social history *(please complete each field and list all members of your family)*

☐ **Check if child is adopted and list birth country:** _____ **and age at adoption:** _____

Name (add last name if different from patient)	Relationship	Age	School grade completed	Any medical, mental health, or school/learning concerns?	Lives in child's home?
	Biological mother				
	Biological father				

Parents' current jobs:

Please list everyone living in the home (step-parent, step-sibling, foster child, uncle, family friend, grandparent, etc.):

Please list any other family members with similar medical or mental health conditions:

Events that happen in the family or home can sometimes have an effect on a person's behavior and learning.

☐ **Check here if you would rather answer this part of the form in person**

Please check if any of the following have been experienced by the family or patient:

- ☐ Someone living in home has a serious health problem
- ☐ A parent has emotional or mental health illness
- ☐ Conflict between parents about parenting
- ☐ Involvement with juvenile court or justice system
- ☐ Recent birth/adoption of another child
- ☐ Running out of food/lack of money to buy food
- ☐ Involvement with social services/ child protective services
- ☐ Separation from parent or out-of-home placement
- ☐ Documentation concerns (immigration)
- ☐ Parent/child conflict
- ☐ Custody disagreement
- ☐ Financial problems
- ☐ Significant sibling conflict
- ☐ Single parent family
- ☐ Foster care placement
- ☐ Abandonment by parent
- ☐ Parent substance/alcohol abuse
- ☐ Unstable housing
- ☐ Exposure to domestic/physical violence in the home
- ☐ Hospitalization for a serious illness
- ☐ Death of parent or sibling
- ☐ Long military deployment of parent
- ☐ Treatment by counselor, psychologist, or psychiatrist
- ☐ Participated in behavior or parent training
- ☐ Neglect
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Separation
- ☐ Divorce

Patient name: _____

Date of birth: _____

Please complete for each page

Child care and education

Does your child go to a child care program? ☐ Yes ☐ No If yes, where?

Does your child go to an early intervention or special education program? ☐ Yes ☐ No

Where?

Does your child go to school or preschool? ☐ Yes ☐ No

Name of the school/program: Current grade:

Has your child repeated any grades? ☐ Yes ☐ No

Does your child receive extra help at school or in the community (check all that apply) :

☐ Learning center / resource room ☐ Occupational therapy ☐ Behavioral plan

☐ Speech therapy ☐ Physical therapy ☐ Feeding plan or protocol

☐ Mental health/counseling (why and how long?): _____

☐ Other (specify): _____

Does child receive any other supports?

☐ Individualized Education Plan (IEP) ☐ 504 Plan ☐ Title I supports ☐ English Learning Class (ELL/ESL)

How do you think your child is doing in school?	Well below grade level	Slightly below grade level	At grade level	Slightly above grade level	Well above grade level
Math					
Reading					
Written language					
Spelling					
Extra-curricular activities/interests?					

Health care contacts	Name	Location
Current primary care provider		
Current specialists: medical, speech, OT, PT, etc. (if any)		
Current dentist		
Current mental health provider (if any)		
Other physicians/clinics where care is received?		
Name of birth hospital		

Patient name: _____

Date of birth: _____

Please complete for each page

Additional information

Is there anything else that is important for us to know about your child?

Patient name: _____

Date of birth: _____

Patient label here

When was child's last hearing test? Date: _____

When was child's last eyesight test? Date: _____

What should we know for your child's visit to go well?

Does child have chances to play with other children? (if not in school or day care programs) ☐ Yes ☐ No

What is child's ethnic/cultural/religious background?

May we call you about taking part in research studies at OHSU? ☐ Yes ☐ No

D3 **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

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

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

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

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

Revised - 1102

American Academy of Pediatrics

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NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0350

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: _____

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NICHQ

National Initiative for Children's Healthcare Quality

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11-19/rev1102

Institute on Development and Disability (IDD)

Child Development and Rehabilitation Center

Autism Program

tel 503 418-2200
877-346-0640
fax 503 494-4447

cdrcnorthunit@ohsu.edu
www.ohsu.edu/autism

Mail code: CDRC
PO Box 574
Portland, OR 97207-0574

Dear Teacher:

One of your student's families is seeking a diagnostic evaluation for their child at the Child Development & Rehabilitation Center. As part of our evaluation process, we ask the child's parent(s) and teacher(s) to complete a set of behavioral rating scales and a brief questionnaire.

Generally, the teacher who spends the most time with the child should complete the teacher rating scale and questionnaire.

Please fill out the forms as completely as possible and at your earliest convenience. Your input is extremely important, and we are unable to proceed with this child's evaluation without receiving information from you.

You may either return the rating scale and questionnaire directly to the parent of your student, or you may mail, email, or fax us the form **if the parents have signed a release of information** form to:

CDRC Intake Office
Oregon Health & Science University
PO Box 574
Portland, OR 97207-0574
Fax: 503 494-4447
cdrcnorthunit@ohsu.edu

Please complete all forms in black ink, make a copy of anything you send in the mail, and always keep originals.

Thank you for your time and effort. We share your concerns for your child and will do everything we can to provide the highest quality service to your family.

Autism Program
Child Development and Rehabilitation Center
Institute on Development and Disability

Institute on Development and Disability (IDD)

Child Development and Rehabilitation Center

tel 503-494-8312
877-346-0640
fax 503-494-4447

cdrcnorthunit@ohsu.edu

Mail code: CDRC
PO Box 574
Portland, OR 97207-0574

BRIEF TEACHER BEHAVIORAL QUESTIONNAIRE

Teacher's name: _____

School Name: _____

School Phone Number: _____

Today's Date: _____

Child's Name: _____ Date of birth:_____

What are this student's biggest strengths as a student and classmate?

_____

_____

_____

Do you have any concerns about the student's behavior? If yes, please briefly describe.

_____

_____

_____

Does the student's behavior interfere with their academics? If yes, please briefly describe.

_____

_____

_____

How does the student interact with his/her peers? (Does his/her behavior get in the way?)

_____

_____

_____

_____

Do you have any other concerns about the student?

What do you think this student needs to be successful in an educational environment?

Does the student receive any extra services at school? (i.e., IEP, 504 plan or other) If yes, please briefly describe.

Has the student had any previous testing done at school? If yes, please briefly summarize or provide copies of the results.

Please feel free to use additional sheets, if necessary.

Child's Name:_____ Date of Birth:_____

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

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

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

Revised - 0303

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National Initiative for Children's Healthcare Quality

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HE0351

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

Today's Date: _____ Child's Name: _____ Grade Level: _____

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

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

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

Comments:

Please return this form to: _____

Mailing address: _____

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Fax number: _____

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

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

Total Symptom Score for questions 1–18: _____

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

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

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

Average Performance Score: _____

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