

Vanderbilt Assessment Follow Up – Teacher Informant

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

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. 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 (pencils, books, toys or assignments)	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. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1		3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following directions	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5



Side Effects: Has the 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
Headaches				
Stomachache				
Change of appetite-explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon or evening- explain below				
Socially withdrawn- explain below				
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				
See or hears things that aren't there				

Explain/Comments:

<p>For Office Use Only Total Symptom Score for questions 1-18: _____ Average Performance Score for questions 19-26: _____</p>
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<p>Please return this form to: _____ Mailing address: _____ _____ Fax number: _____</p>
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Palm Beach Pediatrics, PA

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|--|--|--|---|---|
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| <input type="checkbox"/> Timothy C. Bell, MD | <input type="checkbox"/> Nicole Pearson, MD | <input type="checkbox"/> Dionne Skervin, MD | <input type="checkbox"/> Deborah R. Nuessly, ARNP | <input type="checkbox"/> Nicole Dinovitsner, ARNP |
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