



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 (CIRCLE 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: _____



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OFFICE POLICY

I would like to personally thank you for choosing our office to participate in your child's care and to update you on office policies and procedures. These policies, procedures, office hours and price increases are effective May 1, 2018.

We do accept most insurance. 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 Monday & Tuesday 9:00am-3:30pm and Wednesday, Thursday, & Friday 9:00am-1:00pm.

LATE APPOINTMENTS: If you are more than 15 minutes 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 set appointments scheduled.

INITIAL CONSULTATION: Your initial consultation fee is \$300.00. 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. In your child's initial evaluation, the doctor will go over 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.

FOLLOW-UP VISITS: After your initial evaluation, you will follow up with the doctor every 3-6 months depending on your child's special needs. The cash amount for any follow up visit will be \$125.00 without insurance, and you can expect to be in the office for at least 40 minutes. Please call the office at least 24 hours in advance if you cannot make it. We understand that there are times when you must miss an appointment due to emergencies or other obligations for work or school. However, when you do not call to cancel at least 2 hours prior to an appointment, you may be preventing another patient from getting much needed treatment.

NO CALL/NO SHOW: A \$25.00 fee will be charged to each patient who does not call or show for their scheduled appointment. "No Call/No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid, in full, prior to the next appointment and/or request for the next prescription. Multiple "No Call/No Shows" in any 12-month period may result in termination from this practice, including denial of any future appointments and prescriptions.

PRESCRIPTION REFILLS: You must call the office number at 405-348-6500 for any prescription request. You may have the prescription mailed or you are welcome to pick the prescription up in the office 24 hours after your request. 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. Also, the doctor will only write one prescription per month. **For those of you that have prescriptions for Strattera/Atomoxetine, Intuniv/Guanfacine, Kapvay/Clonidine, Zoloft/Sertraline, Risperdal/Risperidone, Seroquel/Quetiapine, and Lexapro as medication, please call your pharmacy and have them fax a refill request to 405-348-6501.**

PHONE CALLS: Please feel free to call the office at 405-348-6500 for follow up appointments, medication refills, medication updates, ect. All messages will be returned in the order that they were received.

INSURANCE: If your insurance requires an authorization/referral it is your responsibility to contact your child's primary care physician and obtain one, you could have it faxed to 405-348-6501. If your insurance changes, it is your responsibility to contact our office with any changes. See the following list of insurance companies we do/do not accept.



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INSURANCE LISTING

Here's the list of insurance companies we do and do not accept: The highlighted insurance companies are considered OUT-OF-NETWORK.

INSURANCE COMPANIES - APPROVED

Aetna
All Savers
Blue Advantage
Blue Cross Blue Shield
Blue Lincs HMO
Cigna
Coventry Health & Life
First health
First Health Network
FMH Benefits - approved thru Oklahoma Health Network and First Health Network
GEHA - (Government Employee Hospital Association) thru United Healthcare
Golden Rule
Great West Healthcare
Healthcare Highways
Health Choice
HealthSmart
Kempton Company - approved thru Oklahoma Health Network & First Health Network
Mail Handlers
Medicaid/Soonercare
Meritian
Multiplan
OSMA
Pacificaire PPO
Pacificaire HMO - (referral from PCP required before treatment)
Principal - approved thru Oklahoma Health Network & First Health Network
Tricare - Prime (needs referral)
Tricare - Retired
Tricare - Standard
UMR
United Healthcare
UnitedHealth Integrated
WEBTPA

INSURANCE COMPANIES - OUT OF NETWORK

Community Care HMO	PCC Select+
Preferred Community Choice	Global Health
PCC Select	Humana

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.

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 descendants 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.

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 in 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 preceding 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

- | | |
|---|---|
| 1. Does the patient have any ongoing medical problems? <input type="checkbox"/> Y <input type="checkbox"/> N | 5. Did the mother have any medical problems during pregnancy, labor, delivery or post delivery period? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2. Do you have concerns about diet, sleep, exercise? <input type="checkbox"/> Y <input type="checkbox"/> N | 6. Did the patient have difficulty breathing or crying after delivery, have poor color, poor suck, slow growth and development? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 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? <input type="checkbox"/> Y <input type="checkbox"/> N | 7. Is the patient taking any medication at present? <input type="checkbox"/> Y <input type="checkbox"/> N
If yes, list medications: |
| 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? <input type="checkbox"/> Y <input type="checkbox"/> N | 8. Has your child been evaluated by an MD or mental health professional in the past for school or attentional problems? <input type="checkbox"/> Y <input type="checkbox"/> N |

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
1100 Northeast 13th Street
Oklahoma City, OK 73117
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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)

Vanderbilt ADHD Diagnostic Teacher Rating Scale (continued)

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