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Raleigh, NC 27615
www.CarolinaPerformance.net
(919)810-0775

Carolina Performance
FOR EXCELLENCE IN SPORTS, LIFE AND BUSINESS

New Client Intake Form

Name:_____ **Date:**_____

Mailing Address:

_____
_____
_____

Physical Address (if different):

_____
_____
_____

May I send mail to the above address? **Y / N**

Telephone Numbers (Please provide only numbers at which you give me permission to call you):

Home: _____ May leave a detailed message? ___yes ___*no

Work: _____ May leave a detailed message? ___yes ___*no

Cell: _____ May leave a detailed message? ___yes ___*no

Date of Birth/Age:_____ **Relationship Status:** _____

Student status/Occupation: _____

Have you ever engaged in therapy before? Y / N **Worked with a psychiatrist? Y / N**

Contact Person in case of emergency: _____
Telephone #:_____

Primary Care Physician:_____**Telephone#:**_____

Medical History:

- List any medical problems:

_____
_____
_____

- Current Medications:

_____
_____
_____

- Allergies:_____
- Hospitalizations (Medical, Psychiatric, Substance abuse- give place and year):

_____
_____
_____

- Family history of: mental illness? _____Yes _____No
- Substance abuse? _____Yes _____No
- Suicide? _____Yes _____No Violent behavior? _____Yes _____No

- How often do you?

Smoke _____never _____monthly _____weekly _____daily

Drink alcohol _____never _____monthly _____weekly _____daily

Use drugs _____never _____monthly _____weekly _____daily

Primary Insurance:

Insurance Plan Name:_____
Insured Name:_____ Insured ID#_____
Insured's social security #_____
Copayment:_____

How did you hear about our services? _____

_____

What would you like to gain from working with Carolina Performance? What are your goals?

_____

_____

_____

CONSENT FOR TREATMENT:

Your signature below indicates that you have read the Carolina Performance-Client Service Agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form.

_____ _____
Signature of Client (or Guardian if under 18) Date

_____ _____
Printed Name Provider Signature

RECORD RELEASE AUTHORIZATION:

I hereby authorize my Carolina Performance provider to furnish information to insurance carriers concerning my illness/treatment.

_____ _____
Signature of Client (or Guardian if under 18) Date

CREDIT CARD PAYMENT FOR PROFESSIONAL SERVICES

___ VISA ___ Mastercard

_____
Name on Account (exactly as it appears on credit card)

_____
Address (if different from the 1st page)

_____ _____
City ZIP Code

_____ _____ _____
Credit Card Number Exp. Date 3 Digit Security Code
(on the back of the card)

I authorize my Carolina Performance Provider to bill the above credit card for professional services.

_____ _____
Signature of Card Holder Date

PAYMENT FOR LATE CANCELLATION OR NO-SHOW

I authorize my Carolina Performance provider to bill the above credit card when I do not give advanced notice for a late cancellation or no-show, as per the "Carolina Performance – Client Agreement." I understand that if I do not wish my credit card billed for this purpose, I am still responsible for paying these fees.

_____ _____
Signature of Card Holder Date

Professional Disclosure Statement and

Consent for Professional Counseling Services

Darcee Ruble, M.Ed, LPC, LCAS

CAROLINA PERFORMANCE—CLIENT SERVICES AGREEMENT Welcome to Carolina Performance (CP). This document (the Agreement) contains important information about our professional services and business policies. Although Carolina. Performance providers work together with teams and businesses, we have separate, individual private practices in our offices at AIHF. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and heathcare operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between you and your provider. You may revoke this Agreement in writing at any time. That revocation will be binding on CP unless we have taken action in reliance on it; if there are obligations imposed on your CP provider by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Thank you for selecting me as your counselor. I believe the relationship between client and therapist is fundamental for growth and change in counseling and should be based on trust. With this in mind I would like to begin that relationship by telling you about my professional beliefs, experience and your rights. This is also in keeping with with Standards of Practice of the North Carolina Board of Licensed Professional Counselors (NCBLPC) and the North Carolina Substance Abuse Professional Practice Board (NCSAPPB). Please read this and make note of any questions or concerns you have at any time during our sessions.

Qualifications and Experience

I have been working in the helping field for over fourteen years and graduated from Providence College in Providence, Rhode Island in December 2003 with a Masters in Guidance and Counselor Education. Since 2001, while in graduate school, I worked as a substance abuse counselor at the Naval Ambulatory Care Center in Newport, RI. I moved to North Carolina in 2004 and worked as a substance abuse counselor, 2044 with an emphasis on case management. I was licensed in North Carolina as a Licensed Professional Counselor, 6627, in June 2007. I have also held the Licensed Chemical Addiction Specialist, 1613, from the North Carolina Substance Abuse Professional Practice Board since April 2010.

Counseling Philosophy and Approach

I believe that counseling works best when you and I work together as a team to develop goals that best meet your needs. Your progress towards these goals generally happens gradually over time and is enhanced by working on goals outside of therapy as well. Counseling interventions offer great potential for growth but can also cause uncomfortable emotions to arise. This is a normal part of therapy. You may experience any of the following as a result of our work: sadness, guilt, anger, frustration and anxiety. I emphasize that it is very important to explore these feelings in order to make progress towards your goals. As a result of counseling you can gain insight into your life, learn better methods of coping with problems, build self-confidence and have a more positive outlook in general. To sum it up counseling will be a joint effort but can only be successful with your work and determination.

Every person is unique with different strengths and needs. With this in mind I work with you to assess your mental, physical, social, economic and spiritual needs. Once the assessment is complete we will work together to develop a plan for you to achieve your goals. If necessary, I may refer you to your physician to rule out biological causes for your distress. In the case that your situation is beyond my scope of practice I will make every effort to refer you to

professionals more qualified to meet your needs. We have many wonderful psychiatrists and psychologists on staff at Carolina Performance if a referral needs to be made.

I am able to provide individual and group therapy as well as family psycho education for children, adolescents and adults. My counseling style is primarily motivational interviewing but strongly influenced by cognitive behavioral and reality therapy techniques. I am very sensitive to multicultural issues and can provide therapy in Spanish. Our sessions will focus on choices and how your choices affect your goals. If you agree, I may utilize homework assignments such as journaling that will be followed up in subsequent sessions. Above all you can expect me to treat you with respect and caring.

Confidentiality

All information shared will be kept confidential with the following exceptions:

a) If I believe you are a danger to yourself or someone else

b) If you give me written permission to disclose information

c) In the case of abuse to a child or an elderly person confidentiality will be waived

d) If the information is court ordered

e) If you desire to seek reimbursement from a managed care company, the disclosure of confidential information will be required for reimbursement or in the case I need to send information to a collection agency to recoup monies owed.

f) In case of medical emergency

g) If a government agency is requesting the information for health oversight activities, your provider may be required to provide it for them.

h) If a patient files a worker's compensation claim, and a CP provider's services are being compensated through workers compensation benefits, the CP provider must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

i) If a patient files a complaint or lawsuit against CP, CP may disclose relevant information regarding that patient in order to defend CP. If a patient files a complaint or lawsuit against a CP provider, that provider may disclose relevant information regarding that patient in order to defend his or herself.

If one of the above circumstances arises only essential information will be revealed and if possible you will be informed before confidentiality is broken. In case the client is a minor; the parents or legal guardians may be involved in the counseling process when appropriate. Even when the guardian is involved precautions to safeguard confidentiality will be taken in order to have the best interest of the client foremost.

Federal law 42 CFR restricts the use and disclosure of patient information that is received by an alcohol and drug abuse treatment program. Generally, substance abuse information must not be disclosed without your written authorization. For example, I would need your written authorization before disclosing substance abuse information to your insurance provider for the purpose of obtaining reimbursement for service provided to you. Once a diagnosis is disclosed it is a permanent part of your insurance record.

Length of Sessions and Pay Schedule

Payment is expected at time of service. Forms of payment accepted are currently credit card, cash and check. There will be a 35.00 fee for all returned checks.

Each session will last 50 minutes. The standard fee for an intake is $165. The standard fee for an individual or family session is $135. If ADHD testing is required there is an additional charge of $15 per typed page in addition to the intake fee. I am in network with Blue Cross Blue Shield. At times telephone contact is necessary between a therapist and client for purposes other than scheduling sessions. Clients are responsible for payment of the agreed upon fee (on a prorated basis) for any telephone calls longer than five minutes. If you arrive late for an appointment, the appointment must end at the scheduled time. This will allow me to see each client as scheduled. Should you need to cancel or reschedule an appointment, it is requested that you do so with a 24 hour notice. Please call me at 919-810-0775 to cancel the appointment. If an appointment is cancelled or missed without a 24 hour notice, you will be billed your full therapy fee for the missed appointment.

Client Rights and Verification of Consumer Choice

All records are my property, however; they are maintained for your benefit and available for review at your request if they are deemed therapeutically valuable. You have the right to be informed of your counselor's qualifications and the right to accept or decline any suggestions or therapeutic strategies. I will periodically remind you of your rights. You have the right to terminate counseling or resend permission to disclose information at any time. It is suggested that termination be made collaboratively with client and counselor in order to ensure the best outcomes. You have the right to change service providers at any time, if possible, reasonable notice should be given so that I can aid the transition to your new provider.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Emergencies

If you need to contact me please call 919-810-0775. Please note that I may not always be able to return your call immediately due to other commitments. In case of an urgent situation or emergency when you feel the need for immediate support contact the Alliance Behavioral Access 24/7 at 800-510-9132 or call Holly Hill Respond Line at 919-250-7000. You can also call local 911 system or go to the nearest emergency room.

Complaints

If at any time you feel uncomfortable or are dissatisfied with my services or counseling approach please let me know. Hopefully we can make changes to improve the situation. If you do not feel that your concerns are being addressed in a manner that you approve of please contact either of the following boards:

North Carolina Board of Licensed Professional Counselors
PO Box 1369
Garner, NC 27529-1369
(919)661-0820

North Carolina Substance Abuse Professional Practice Board
PO box 10126
Raleigh, NC 27605
(919) 832-0975

Consent for Treatment

By signing below you are stating that you have read and understand this disclosure and that all your questions have been answered. That you agree to have your insurance charged and/or pay all fees. You have received a copy of

HIPAA regulations. It also indicates that you are consenting to receive counseling services.

Client Name	**Client/Parent/Guardian Signature**	**Date**

Darcee L. Ruble, M.Ed, LPC, LCAS	**Date**

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

The information gathered on this form can be used when writing a Social/Developmental History.

I. GENERAL INFORMATION

Child's full name_____ Grade_____ Age_____ DOB_____

Current Address: _____ How long at this address? _____

Person providing information: _____ Relationship to child_____

Who does child live with: □ both parents □ mother □ father □ other (specify) _____

Biological father_____ Occupation_____ Years education: _____
Father's home phone_____ Work #_____ Cell #_____

Biological mother_____ Occupation_____ Years education: _____
Mother's home phone _____Work #_____ Cell #_____

□ N/A Guardian's name_____ Occupation _____Years education_____
Guardian's home phone _____ Work #_____Cell #_____

Please list all people in child's immediate family:

Name	Relationship to child	Age / Grade	Living in house?

Please list all other *non-family* members who live in household:

Name	Relationship to child/family	How long has lived in household?

Language(s) spoken at home _____ Primary Language at home_____

Please list all locations (city, state) that your child has lived:

1. Birthplace _____ Moved at age/grade _____
2. _____ Moved at age/grade _____
3. _____ Moved at age/grade _____
4. _____ Moved at age/grade _____

Are biological parents of child currently: □ married □ separated □divorced □ never married

- If separated or divorced, who has *legal* custody? □ mother □ father □ other (specify): _____
- If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

Are there other adults who have a *significant* part in raising your child? □Yes □No
If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.)_____

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc)
_____
_____

What do you feel are your child's…
Strengths_____
Weaknesses _____

Briefly describe your concerns for your child.
_____
_____
_____

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is child your: □ biological child □ adopted child □ foster child □ other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used: _____
_____

Pregnancy lasted _____weeks / months Child's birth weight: _____pounds ____ounces

APGAR score …at 1 minute____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No
If No, explain why: _____

Please check the conditions below that describe the health of the child and mother during…

Mother's Pregnancy
- □ No Complications
- □ Blackouts
- □ Falls
- □ Physical Injury
- □ Blackouts
- □ Excessive Bleeding
- □ Hypertension
- □ Diabetes
- □ Emotional Stress
- □ Toxemia
- □ Alcohol/Drug Use
- □ Use of Tobacco

Child's Delivery
- □ Normal
- □ Induced Labor
- □ C-Section
- □ Breech birth
- □ Unusually long labor (>12 hrs)
- □ Premature # of weeks_____
- □ Overdue # of weeks_____
- □ Other Problem (Specify) _____

_____
_____
_____
_____

Child's Condition at Birth
- □ Normal / No problems
- □ Lack of Oxygen
- □ Breathing Problem
- □ Birth Injury/Defect:
- □ Jaundice
- □ Newborn ICU # of days _____
- □ Other Problem (Specify) _____

_____
_____
_____
_____
_____

B. Health

Describe the state of your child's current health: □ Excellent □ Good □ Fair □ Poor

Is your child currently taking any medication? □Yes □ No
If yes, please list medications and uses: _____

Has your child ever been identified as having a disability? □Yes □ No
If so, by whom, what age, & what disability? _____

Has your child ever received psychological counseling? □Yes □ No
If "yes," by whom (professional/agency) and when: _____

Has your child had any of the following?	Please describe and give details, dates, and/or age onset
□ Serious Illnesses	
□ Head Injuries	
□ Seizures or convulsions	
□ Surgery/Hospitalization	
□ History of Ear Infections	
□ Allergies and/or Asthma	
□ Vision Problems	
□ Hearing Problems	
□ Frequent Nightmares and/or Bedwetting	
□ Other health problem:	

Is there a *family history* for the following problems?	*Biological* family member with the history… (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc)
□ Learning Difficulties (reading, math, writing, spelling)	
□ Speech or Language problem (articulation, stuttering, etc.)	
□ Developmental Disorder (such as Autism, Aspergers, etc.)	
□ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
□ Mental Retardation	
□ School Failure (failing grades, dropout, etc)	
□ Drug or Alcohol Addiction	

C. Development

Please indicate the age or age range when your child performed the following milestones:

Milestone:	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Sat up without help							
Crawled							
Walked alone							
Walked up stairs							
Spoke first words							
Spoke short phrases							
Spoke sentences							
Fully bladder trained							
Fully bowel trained							
Stayed dry all night							

III. BEHAVIOR

A. Behavior in Infancy

During you child's first *few years of life*, were any of the following present to *significant* degree?

- □ Did not enjoy cuddling
- □ Was not easily calmed by being held or stroked
- □ Difficult to comfort
- □ Colicky
- □ Excessive irritability
- □ Diminished sleep
- □ Difficult nursing
- □ Poor eye contact/did not turn towards caregivers
- □ Did not respond to name or speech of caregivers
- □ Fascination with certain objects
- □ Constantly into everything
- □ Frequent head banging

* If checked any above, please describe_____

_____

B. Child's Early Temperament: (*Toddler through five years of age*)

❖Activity Level – How active has your child been from an early age?

_____

_____

❖Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks?

_____

_____

❖Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way?

_____

_____

❖Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)?

_____

_____

❖Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.?

_____

_____

❖Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament?

_____

_____

❖Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.?

_____

_____

Prior to age six, did your child have more difficulty than other children his/her age…

- □ Sitting still at meal time
- □ Paying attention when read to
- □ Throwing a ball
- □ Catching a ball
- □ Buttoning & Zipping
- □ Holding crayon or pencil
- □ Accidentally dropping things
- □ Staying focused on TV, movies, or video games
- □ Waiting for turn at play
- □ Knowing left and right
- □ Acting without thinking
- □ Dressing self
- □ Tying shoe laces
- □ Accidentally knocking things over

C. Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- □ Destructive behavior
- □ Is affectionate with family and friends
- □ Responds well to authority figures
- □ Boundless energy and poor judgment
- □ Withdrawn and/or sullen
- □ Cruelty to animals
- □ Disorganized, loses things often
- □ Shows sudden outburst of physical aggression
- □ Frustrated easily
- □ Shifts from one activity to another
- □ Has difficulty playing quietly
- □ Requires a lot of parent attention
- □ Fidgets or squirms in seat
- □ Appears to daydream or "zone out" often
- □ Appears depressed & unhappy much of the time
- □ Explosive temperament
- □ Frequently complains about aches and pains
- □ Appears to have low self-esteem
- □ Prefers to be alone (or considers self "a loner")
- □ Starts fires
- □ Lacks motivation
- □ Steals or lies
- □ Becomes upset with change
- □ Fearfulness
- □ Frequent peer and/or family conflicts
- □ Does not appear to listen to what is being said
- □ Always worrying about something
- □ Nervous habits (nail biting, hair twirling, etc.)

D. Home Behavior:

How often each of the following settings a *problem** for your child?
**Problems* include: doesn't follow directions/rule, needs reminders, arguments/fights, whines/cries, fidgets/squirms, etc.

• While getting ready for school…	□ Rarely	□ Sometimes	□ Frequently
• When eating at the dinner table	□ Rarely	□ Sometimes	□ Frequently
• When playing by him/herself	□ Rarely	□ Sometimes	□ Frequently
• When playing with siblings / children in neighborhood…	□ Rarely	□ Sometimes	□ Frequently
• When with a babysitter or at daycare…	□ Rarely	□ Sometimes	□ Frequently
• In public places where needs to behave (church, store, etc)	□ Rarely	□ Sometimes	□ Frequently
• When in the car…	□ Rarely	□ Sometimes	□ Frequently
• When told to do something he/she doesn't want to do	□ Rarely	□ Sometimes	□ Frequently
• During sit-sown homework time…	□ Rarely	□ Sometimes	□ Frequently
• When watching TV or playing a video game	□ Rarely	□ Sometimes	□ Frequently

How would you describe your child's personality at home?
_____
_____

How does your child get along with brothers/sisters? _____
_____

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* that your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.)_____
_____

How does your child respond to discipline? _____

List any responsibilities your child has at home: _____
_____

Does your child do these regularly? □Yes □ No Does your child need frequent reminders? □Yes □ No

Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM Does child sleep well? _____

How much time does your child typically spend on electronic media?
Watching T V: _____hrs/day; Playing video/computer games: _____hrs/day; Other_____: _____hrs/day

Have any family members expressed concerns about your child's behavior? □ Yes □ No
Explain: _____

E. Social Behavior:

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?)
_____
_____

How does your child interact with children in the neighborhood?
_____
_____

IV. Educational History

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____
How much of a struggle is homework? □ Not a struggle □ Sometimes a struggle □ Often a struggle

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? □ Yes □ No
If yes, which program and when services begin_____
_____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool / Daycare_____
_____
_____
Elementary School_____
_____
_____
_____
_____
Middle School_____
_____
_____
_____
High School _____
_____
_____

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

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

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

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

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

Revised - 1102

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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: _____

_____

Fax number: _____

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 19–28: _____

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: _____