



## **ADHD EVALUATION PACKET**

In order to properly evaluate your child for attention and school difficulty we need to obtain the following information both from you and your child's educator(s). Please submit all information together at least 2 WEEKS PRIOR to the initial appointment in order to allow the physician time to review and interpret the information. If we do not receive this information we may ask you to reschedule the appointment as we cannot do an adequate evaluation without the complete packet returned.

Included in this packet you will receive the following:

*For parent to complete-*

- **ADHD INITIAL PATIENT HISTORY** This history should be completed by a parent/guardian knowledgeable about the child/family's history.
- **NICHQ VANDERBILT ASSESSMENT SCALE- PARENT INFORMANT** Each parent/guardian should complete his/her own survey (copy as needed).

*Give to your child's teacher(s)-*

- **AUTHORIZATION FOR DISCLOSURE** This form should be completed by a parent/guardian and given to the teacher(s) to allow information to be shared between the clinic and teachers.
- **TEACHER QUESTIONNAIRE and NICHQ VANDERBILT ASSESSMENT SCALE** TEACHER INFORMANT please give to each of your child's teacher(s) for them to complete and collect in a confidential envelope once completed (copy as needed).

Complete information at least 2 WEEKS PRIOR to your initial appointment in order for us to properly review and score the surveys. We will review this information with you and your child at the first appointment. Return completed forms to:

**Creekmore Clinic  
216 Oxford Road  
New Albany MS 38652**

Please be aware that several visits and further evaluation may be needed before a diagnosis of ADHD can be made or ruled out and treatment started.

Thank you.

Sincerely,

**Creekmore Clinic**



Patient Name: \_\_\_\_\_  
Appointment Date: \_\_\_\_\_

## ADHD

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Date Completed: \_\_\_\_\_

PLEASE SUMMARIZE YOUR CONCERNS:

WHEN DID THESE PROBLEMS BEGIN?

PLEASE LIST ANY PRIOR EVALUATIONS DONE AND ATTACH RESULTS IF ABLE:

DATE	NAME OF EVALUATOR



**Authorization for Disclosure of Protected Health Information**  
(Please sign and give to your child's teacher(s))

Child's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

I hereby authorize the school below to release information to and receive assessment results from:

School \_\_\_\_\_

Contact Person Title \_\_\_\_\_

Telephone # \_\_\_\_\_

Address \_\_\_\_\_

City State Zip \_\_\_\_\_

Information to be released to **Creekmore Clinic** at:

**216 Oxford Road  
New Albany MS 38652**

Information being requested:

☒ Teacher Questionnaire

☒ NICHQ Vanderbilt Assessment

☒ Recent psychometric, academic, any current IEP/504 plan in use and behavioral assessments

Other: \_\_\_\_\_

Signature Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

City State Zip \_\_\_\_\_

Home Phone# Work Phone# \_\_\_\_\_



**CHILD'S NAME** \_\_\_\_\_

**PARENT'S NAME** \_\_\_\_\_

**Dear Teacher/Counselor,**

**We are currently evaluating one of your students for concerns regarding ADHD. In order to complete this evaluation we are asking you to complete the following questionnaire and rating scale. Each teacher should complete a separate questionnaire and survey. Once completed please return the form to the parent in a sealed confidential envelope as soon as possible so it can be returned to us.**

**In addition to the questionnaire and survey, it would be helpful to receive copies of any evaluations done at the school. These may include achievement tests or educational assessments, IEP reports, 504 plans, or school psychologist reports.**

**A signed Authorization for Disclosure of Protected Health Information by the parent/guardian is also enclosed.**

**Thank you for your assistance and cooperation in the completion of these forms. Please call if you have any questions regarding the enclosed material.**

**Sincerely,**

**Creekmore Clinic**



## INITIAL PATIENT HISTORY

### **FAMILY**

HAS ANYONE IN THE FAMILY (PARENT, SIBLING, GRANDPARENT, AUNT, UNCLE, COUSIN) EVER HAD DIFFICULTY WITH THE FOLLOWING

	YES	NO	RELATION	COMMENTS
<b>LEARNING PROBLEMS</b>				
READING				
MATHEMATICS				
SPEECH				
REPEATED A GRADE				
GIFTED				
MENTAL RETARDATION				
<b>BEHAVIOR PROBLEMS</b>				
ADHD				
TROUBLE IN SCHOOL				
TROUBLE WITH THE LAW				
HIGH SCHOOL DROP OUT				
<b>MENTAL HEALTH PROBLEMS</b>				
DEPRESSION				
ANXIETY				
OBESSIVE COMPLUSIVE DISORDER				
SUICIDE ATTEMPT/COMPLETION				
PHYCHIATRIC HOSPITALIZATION				
DRUG/ALCOHOL ABUSE				
DIFFICULTY HOLDING A JOB				
<b>MEDICAL PROBLEMS</b>				
AUTISM/ASPERGER'S SYNDROME				
THYROID DISEASE				
TIC/TOURETTE'S DISORDER				
HEART PROBLEM				
SEIZURE				
GENEIC CONDITION				
OTHER				

ANY OTHER COMMENTS/CONCERNS?



## INITIAL PATIENT HISTORY

### HOME

PLEASE DESCRIBE ANY CONCERNS YOU HAVE ABOUT YOUR CHILD AT HOME:

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HOW WOULD YOU DESCRIBE YOUR CHILD'S CURRENT

OVERALL MOOD \_\_\_\_\_

HOMEWORK HABITS \_\_\_\_\_

CHORE RESPONSIBILITIES/COMPLETION \_\_\_\_\_

LISTENING SKILLS \_\_\_\_\_

SLEEP HABITS \_\_\_\_\_

DIET \_\_\_\_\_

RELATIONSHIP WITH PARENTS/SIBLINGS \_\_\_\_\_

DISCIPLINE \_\_\_\_\_

WITH WHOM DOES YOUR CHILD LIVE? (IF SIBLINGS, WHAT ARE THEIR AGES?)

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PARENTS ARE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ NEVER MARRIED

IF DIVORCED/SEPARATED, WHAT ARE CUSTODY AND LIVING ARRANGEMENTS?

WHAT ARE THE CURRENT FAMILY STRESSORS?

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## INITIAL PATIENT HISTORY

PLEASE LIST ANY CHRONIC OR SERIOUS MEDICAL CONCERNS:

DATE	MEDICAL CONCERNS

PLEASE LIST ANY HOSPITALIZATIONS OR SURGERIES:

DATE	HOSPITALIZATION/SURGERY

CURRENT MEDICATIONS (INCLUDING VITAMINS/HERBALS):

MEDICATION	DOSAGE FREQUENCY

ALLERGIES TO MEDICATIONS, FOODS, POLLENS, ETC: ☐ NONE

IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO



## INITIAL PATIENT HISTORY MEDICAL

HAVE YOU OR YOUR CHILD'S PHYSICIAN EVER HAD CONCERNS REGARDING THE FOLLOWING?

IF SO, AT WHAT AGE?

	YES	NO	AGE	COMMENTS
PREMATURE BIRTH				
DEVELOPMENT				
GROWTH				
WEIGHT LOSS				
WEIGHT GAIN				
HEAD SIZE				
SPEECH DEVELOPMENT				
UNDERSTANDING LANGUAGE				
MEMORY				
APPETITE				
SLEEP				
HEADACHES				
STOMACH ACHES				
RECURRENT VOMMITING				
TICS				
FAINTING				
CHEST PAIN				
TROUBLE BREATHING				
ASTHMA				
DAY OR NIGHT STOOL ACCIDENTS				
DAY OR NIGHT URINE ACCIDENTS				
CONSTIPATION				
DIARRHEA				
HAIR LOSS				
SKIN CHANGES/BIRTHMARKS				
HEARING PROBLEMS				
VISION PROBLEMS				
HEAD INJURY/CONCUSSION				
ANXIETY				
DEPRESSION				
CHEMICAL DEPENDENCY				
OTHER (DESCRIBE)				



## INITIAL PATIENT HISTORY

### SCHOOL

NAME OF SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PLEASE DESCRIBE YOUR CHILD'S CURRENT SERVICES THEY RECEIVE AT SCHOOL (i.e. tutors, special education classes, gifted services, etc). PLEASE ATTACH A COPY OF ANY IEP OR TESTING COMPLETED.

WHAT HAVE TEACHERS MENTIONED AND HOW HAVE THEY ADDRESSED THE FOLLOWING CONCERNS:

DOES YOUR CHILD HAVE ANY IN CLASSROOM INTERVENTIONS TO ADDRESS THE FOLLOWING?

BEHAVIOR? \_\_\_\_\_

WORK COMPLETION/HOMEWORK? \_\_\_\_\_

ACADEMIC PROGRESS? \_\_\_\_\_

HANDWRITING/NEATNESS? \_\_\_\_\_

CARELESS MISTAKES? \_\_\_\_\_

DISTRACTION/ATTENTION? \_\_\_\_\_

HAVE ANY OF THESE CONCERNS BEEN MENTIONED BY PRIOR TEACHERS?

WHAT IS YOUR CHILD'S CURRENT AFTER SCHOOL ARRANGEMENTS?

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## TEACHER QUESTIONNAIRE

Please rate the child's ability in the following for his/her grade level:

	Failing	Below average	Average	Above average	superior
Reading					
Arithmetic					
Spelling					
handwriting					
Written expression					
Overall academic Achievement					
Social Interactions					

**PLEASE DESCRIBE THIS CHILD'S STRENGTHS AND DIFFICULTIES AS YOU SEE THEM.**

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**PLEASE LIST ANY SPECIFIC QUESTIONS AND/OR AREAS IN WHICH YOU WOULD LIKE TO HELP THIS CHILD.**

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**ANY ADDITIONAL COMMENTS.**

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## TEACHER QUESTIONNAIRE

Child's Name \_\_\_\_\_ Date Completed \_\_\_\_\_

School Name \_\_\_\_\_ Child's Grade \_\_\_\_\_

Teacher's Name \_\_\_\_\_ Subject Taught \_\_\_\_\_

Hours with child (daily average) \_\_\_\_\_

Number of students in class \_\_\_\_\_

How long have you known this child? \_\_\_\_\_

Is this child absent often? \_\_\_\_\_

Has this child repeated/skipped any grades? \_\_\_\_\_

Has this child had any or planned to have any IQ or educational assessments? \_\_\_\_\_

If so, what is the child's Full IQ \_\_\_\_\_ Verbal IQ \_\_\_\_\_ Performance IQ \_\_\_\_\_

Does this child have an IEP? \_\_\_\_\_ (if so please attach copy of most recent)

Please describe any special help/services this child receives in and outside of the classroom:

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**Consent to Treat Minor Patient-Without Parent/Legal Guardian Present**

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: \_\_\_\_\_ DOB: \_\_\_\_\_

For those occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

**LIMITATIONS:**

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent may only apply to minors age 16 and older.

This consent shall be in effect for: ☐ Date \_\_\_\_\_ (only)

☐ Indefinitely, until revoked by written communication

**AUTHORIZATION:**

I (parent/guardian name) \_\_\_\_\_ request and authorize Creekmore Clinic and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Creekmore Clinic and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations)

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

\_\_\_\_\_  
Parent or Legal Guardian (please print)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date