Children's MINNESOTA

Our Community Clinics
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

SCHOOL PROBLEMS EVALUATION MEDICAL HISTORY FORM

Child's name: ______________________________

Birthdate: ______________________ Date form filled out: ______________________

Your name: ______________________ Primary Phone: ______________________

Relationship to child: ______________________ Secondary Phone: ______________________

Home Address: ______________________________

City: ______________________ State: ________ Zip: ______________________

Name of School: ______________________ Grade: ______________________

Referred by: ______________________________

Child's private physician: ______________________________

Please list any previous evaluations or treatment for the current problems and attach copies if available:

Date — Name of Physician, psychologist, agency, or clinic

____

____

____

Please attach a recent picture:

September, 2016

Name: ______________________ Date of Birth: ______________

Please list the problems with which you want help for your child:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

When did these problems begin? ______________________

What do you hope to get out of this evaluation? ______________________

____

____

SCHOOL

Please describe your child's current classroom placement and services (attach an Individual Educational Plan [IEP] and copies of any school psycho-educational reports if available):

Special Services | Time/days per week

____

____

____

Please indicate current classroom interventions:

- ❒ Behavior chart
- ❒ Seating preference
- ❒ Time to think or behavior room
- ❒ Social skills group
- ❒ Other______________________

School performance: What has the school told you about your child’s:

Behavior? ______________________

____

Work completion? ______________________

____

Academic progress? ______________________

____

Does your child often bring home work that should have been done during class time? ❒ Yes ❒ No

Handwriting/ neatness: ______________________

____

Please describe previous day care, preschool or school problems:

Grade/year	School/Center name	Problems

Name: ______________________ Date of Birth: ______________

HOME/FAMILY

Family Member	Name	Years of School/Degree	Occupation
Father			
Mother			
Stepfather			
Stepmother			

Parents are: ❒ married ❒ separated ❒ divorced ❒ never married

Please share any history of significant (if any) marital problems: ______________________

Custody arrangements if applicable: ______________________

Who lives at home with this child? ______________________

Briefly describe any behavior or family issues that bother you in regard to this child:

Please describe any conflict surrounding homework: ______________________

Please describe how you discipline your child: ______________________

SOCIAL

How many close friends does your child have? ______________________

Describe any problems your child may have in making and keeping friends: ______________________

Please describe any aspect of your child's social life that bothers you: ______________________

List the organized or leisure time activities your child participates in (e.g.., sports, scouts, religious, free time play):

How many hours per day does your child watch TV and play video games? ______________________

Name: ______________________________ Date of Birth: ____________________

SELF-ESTEEM

How do you feel these problems are affecting your child's self-esteem? ______________________

PAST MEDICAL HISTORY

Was this child adopted? ❒ Yes ❒ No

PREGNANCY

Was this pregnancy planned? ❒ Yes ❒ No

PREGNANCY COMPLICATIONS	Yes	No
Bleeding		
Premature labor		
High blood pressure		
Toxemia		
Infections		
Weight gain less than 15 lbs.		
Diabetes		
Smoking		
Drug use *		
Alcohol use: # of drinks/day ________		
Emotional or family problems *		
Previous stillborns/miscarriages		

Specify any medications/drugs or other details:

LABOR AND DELIVERY:

Length of pregnancy: ____________________ Type of delivery: ❒ Vaginal ❒ Cesarean

Mother's age at delivery: ____________________

Complications:

- ❒ fetal distress (heart rate drop)
- ❒ meconium (bowel movement) passage before birth
- ❒ forceps use
- ❒ breech delivery
- ❒ other, describe ______________________________

NEWBORN HISTORY:

Birth weight: _________ lbs. ________ oz.

Complications at birth (check those that apply):

- ❒ None
- ❒ Needed oxygen
- ❒ Difficulty breathing/respiratory distress
- ❒ Treated in an intensive care unit (NICU)
- ❒ Jaundice
- ❒ Low blood sugar
- ❒ Infection/ pneumonia
- ❒ Other: ____________________

Name: ______________________________ Date of Birth: ______________

GROWTH

Has your child had any problems with (if yes, please describe):

Weight loss or gain: ❒ No ❒ Yes: ______________________________

Growth in height or length: ❒ No ❒ Yes: ______________________________

Head size: ❒ No ❒ Yes: ______________________________

Additional details or comments: ______________________________

DEVELOPMENT

Did your child's development seem normal compared to other children? ❒ No ❒ Yes

Developmental milestone	Age Achieved
Rolled over	
Sat alone	
Walked alone	
First words (mama-dada)	
Two word sentences	
Toilet trained – days	
Toilet trained – nights	
Dress self	

BEHAVIOR HISTORY:

If your child has experienced any of these behavior problems, please record the ages they occurred.

BEHAVIOR	NO	YES	AGES
Colic			
Infant feeding problems			
Difficulty falling asleep			
Difficulty staying asleep			
Excessive crying			
Tantrums			
Difficulty being consoled			
Overactivity or hyperactivity			
Difficulty keeping to a schedule			
Difficulty being satisfied or easily bored			
Thumb sucking			
Impulsiveness			
Anxiety, fears, phobias, excessive worry			
Obsessive or compulsive behaviors			

Name: ______________________________ Date of Birth: ____________________

FAMILY HISTORY

These problems sometimes run in families. We are interested if anyone in your family other than your child may have any of these. Place an X in the appropriate column for each affected family member. If more than one brother or sister has one of these problems, put an X for each one in the appropriate column.

FAMILY HISTORY	Child's mother	Child's father	Child's brother(s)	Child's sister(s)	Others (Specify)
LEARNING					
Difficulty with reading					
Difficulty with arithmetic/math					
Difficulty with writing/spelling					
Speech problems					
Held back in school					
Honor student					
Mental retardation					
BEHAVIOR					
Hyperactivity/ADD/ADHD					
Behavior problems before age 12					
Behavior problems as a teenager					
Trouble with law					
Dropped out of high school					
MENTAL HEALTH					
Depression/manic depression/bipolar					
Obsessive compulsive disorder					
Anxiety disorder					
Suicide attempted/committed					
Psychiatric hospitalization					
Participated in psychotherapy					
Drug or alcohol abuse					
Smoking or chewing tobacco					
MEDICAL/NEUROLOGICAL					
Seizures or convulsions					
Tics, twitches, or Tourette's syndrome					
Thyroid problems					
High blood pressure					
High cholesterol					
Kidney disease					
Asthma/allergies					
Cancer					
Other					

Father's age: ____________

Mother's age: ____________

Sister(s) name and ages: ______________________________

Brother(s) name and ages: ______________________________

Name: ______________________________ Date of Birth: ______________________

FAMILY HEART HISTORY:

If a member of your child's family has had any of these medical problems, please record their relationship to your child.

PROBLEM	NO	YES	RELATIONSHIP
Sudden, unexpected, unexplained death before age 50			
Died suddenly of "heart problems" before age 50			
Unexpected fainting or seizures			
Enlarged Heart: Hypertrophic Cardiomyopathy			
Dilated Cardiomyopathy			
Heart Rhythm problems: Long QT Syndrome			
Short QT Syndrome			
Brugada Syndrome			
Catecholaminergic Ventricular Tachycardia			
Arrhythmogenic Right Ventricular Cardiomyopathy			
Wolff-Parkinson-White Syndrome			
Cardiac Arrhythmias (irregular heart beat)			
Marfan Syndrome			
Heart attack occurring before age 35			
Pacemaker or implanted defibrillator			
Event requiring resuscitation in family member less than 35 years old			

CHILD'S HEART HISTORY:

If your child has experienced any of these medical problems, please record the ages they occurred:

PROBLEM	NO	YES	IF YES, PLEASE EXPLAIN
Fainting or dizziness during or after exercise			
Extreme shortness of breath during exercise (without asthma)			
Extreme fatigue with exercise (different from peers)			
Palpitations, increased heart rate, extra or skipped beats			
Rheumatic Fever			
An unexplained seizure			
Heart murmur			
An unexplained, noticeable change in exercise tolerance			
High Blood Pressure			
Previously detected Cardiac Disease			

CHILD'S MEDICAL HISTORY:

Are immunizations up to date? ❒ No ❒ Yes (Please include a copy of current immunization records)

Describe any serious reactions: ______________________________

List any known allergies to medications, foods, pollens or inhalants: ______________________________

____

____

Describe any hospitalizations or surgery (date, reason, problems): ______________________________

____

____

Describe or list any chronic or serious past illnesses (include dates, medications, etc.): ______________________________

____

____

Name: ______________________________ Date of Birth: ____________________

MEDICATIONS:

Please list currently prescribed or over the counter medications taken and their doses:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

REVIEW OF SYSTEMS:

If your child has experienced any of these medical problems, please record the ages they occurred:

MEDICAL PROBLEM	NO	YES	AGES
Food reactions			
Appetite problems			
Underweight or overweight			
Difficulty sleeping			
Skin rashes – chronic or frequent			
Hair loss			
Unusual moles or birthmarks			
Recurrent or frequent ear infections			
Hearing loss			
Visual problems or wears glasses			
Recurrent tonsillitis			
Sinus infections			
Asthma, wheezing, exercise intolerance			
Bronchitis			
Pneumonia			
Stomachaches			
Diarrhea			
Constipation			
Soiled underwear			
Recurrent vomiting			
Bloody stools			
Daytime wetting			
Bedwetting			
Menstrual periods Problems			
Age menstruation started _______			
Joint pain or backache			
Scoliosis			
Diabetes			
Seizures or convulsions			
Headaches			
Tics, twitches, or involuntary movements or noises			
Serious head injury or knocked out			
Other (specify)			

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PARENT SCHOOL PROGRESS FOLLOW-UP EVALUATION

Parent to Complete in the month of __________

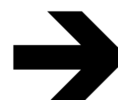
Child's Name: __________________________ Date of Birth: ____________________ Today's Date: ______________

Parent's Name: ____ Parent's Phone Number: ________________

- Are your child's ADHD symptoms controlled consistently throughout the day? ❑ Yes ❑ No
- If your child is currently taking ADHD medication, how long does it control his/her symptoms? _______ Hours.
- Are your child's ADHD symptoms controlled during after-school hours including homework time? ❑ Yes ❑ No
- If not, what ADHD symptoms are not adequately controlled during this time? ________________________________
- Do you feel that your child needs more symptom control than what is provided by his/her current ADHD treatment plan? ❑ No ❑ Yes
- Do you feel that your child's current or prior ADHD medication is/was well tolerated? ❑ Yes ❑ No

Symptoms While on Medications	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 and/or activities.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehavior.	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. Is fearful, anxious, or worried.	0	1	2	3
28. Is afraid to try new things for fear of making mistakes.	0	1	2	3
29. Feels worthless or inferior.	0	1	2	3
30. Blames self for problems, feels guilty.	0	1	2	3
31. Feels lonely, unwanted, or unloved; complains that "no one loves him or her".	0	1	2	3
32. Is sad, unhappy, or depressed.	0	1	2	3
33. Is self-conscious or easily embarrassed.	0	1	2	3

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



Continued on Reverse

Name: ____________________ Date of Birth: ____________

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
34. Overall school performance	1	2	3	4	5
35. Reading	1	2	3	4	5
36. Writing	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Relationships with parents.	1	2	3	4	5
39. Relationships with siblings.	1	2	3	4	5
40. Relationships with peers.	1	2	3	4	5
41. Participation in organized activities (e.g. teams)	1	2	3	4	5

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	NONE	MILD	MODERATE	SEVERE
Change of appetite	0	1	2	3
Weight loss	0	1	2	3
Trouble sleeping	0	1	2	3
Dull, tired, listless behavior	0	1	2	3
Chest pain	0	1	2	3
Stomachache	0	1	2	3
Headache	0	1	2	3
Tremors/feeling shaky	0	1	2	3
Repetitive movements, tics, jerking, twitching, eye blinking	0	1	2	3
Picking at skin or fingers, nail biting, lip or cheek chewing	0	1	2	3
Irritability in the late morning, late afternoon, or evening	0	1	2	3
Problem behaviors when medications are wearing off	0	1	2	3
Excessive worrying, anxiety	0	1	2	3
Sees or hears things that aren't there	0	1	2	3
Socially withdrawn – decreased interaction with others	0	1	2	3
Extreme sadness or unusual crying	0	1	2	3
Dizziness	0	1	2	3
Skin rash	0	1	2	3

COMMENTS:

For Office Use Only

Inattention 1-9: ________/9 Hyp-Imp 10-18: ________/9 ODD 19-26: ________/8 Dep / Anx 27-33 ________/7

Strengths: Weaknesses:

Provider Initials:____________

Children's MINNESOTA

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

MRN: ________________(*office use only*)

<u>**Children's Minnesota**</u>
Health Information Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information
Fax: 612-813-5980

(***Office use only***)
Staff Initials _________

# of pages ___________

ID Verified: ☐ **Yes**
Comments:

____
____
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____
____

How to upload to MyChildren's portal

1. Print and complete this form.
2. Scan or take a photo of your completed form.
3. Log in to your MyChildren's account.
4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management.**

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name ____ Date of Birth ______________

I authorize (release from):

____
Hospital/Clinic/School/Other

____ ____________________
Address/City/State/Zip Phone/Fax

To release To: ____
Name/Hospital/Clinic/School/Other

____ ____________________
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: ___________________________

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

Information needed by (date): ____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: ____________________________________

Information needed from the following clinics:
☐Children's Heart Clinic ☐Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Other:_______________________________________
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

Release Method requested: ☐ **Paper** ☐ **Fax (patient care only)** ☐ **Verbal** ☐ **MyChildren's**

☐ **Email**____**(HIM only)**

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: ______.
  I don't want the following records released: ______________________________________.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** ____

____ ______________________
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _________________________________

Children's MINNESOTA

30342 (12/18)

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

MRN: ________________(*office use only*)

Children's Minnesota
Health Information Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information
Fax: 612-813-5980

(*Office use only*)
Staff Initials _________

# of pages ___________

ID Verified: ☐ **Yes**
Comments:

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4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management.**

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name ____ Date of Birth _______________

I authorize (release from):

____
Hospital/Clinic/School/Other

____ ________________________
Address/City/State/Zip Phone/Fax

To release To: ____
Name/Hospital/Clinic/School/Other

____ ________________________
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: ___________________________

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

Information needed by (date): ____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: _____________________________________

Information needed from the following clinics:
☐Children's Heart Clinic ☐Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Other:_______________________________________
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit

☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

Release Method requested: ☐ **Paper** ☐ **Fax (patient care only)** ☐ **Verbal** ☐ **MyChildren's**

☐ **Email**____**(HIM only)**

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: ______.
  I don't want the following records released: ______________________________________.
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- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** ____

____ ________________________
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _________________________________

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Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

TEACHER SCHOOL PROGRESS FOLLOW-UP EVALUATION

Teacher to Complete in the month of ____________________

Child's Name: ______________________________ Grade Level: _______Today's Date: __________________

Teacher's Name: ______________________ Class Name/subject: _____________ Class Time /Period: ________

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 and/or activities.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehavior.	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. Is fearful, anxious, or worried.	0	1	2	3
28. Is afraid to try new things for fear of making mistakes.	0	1	2	3
29. Feels worthless or inferior.	0	1	2	3
30. Blames self for problems, feels guilty.	0	1	2	3
31. Feels lonely, unwanted, or unloved; complains that "no one loves him or her".	0	1	2	3
32. Is sad, unhappy, or depressed.	0	1	2	3
33. Is self-conscious or easily embarrassed.	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
34. Following directions	1	2	3	4	5
35. Disrupting class	1	2	3	4	5
36. Assignment completion	1	2	3	4	5
37. Organizational skills	1	2	3	4	5
38. Relationships with peers	1	2	3	4	5
48. Reading – accuracy of work completed	1	2	3	4	5
49. Mathematics – accuracy of work completed	1	2	3	4	5
50. Written expression - accuracy of work completed	1	2	3	4	5

Please add comments on page 2

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

Child's Name: ______________________________ Date of Birth: ____________________

COMMENTS:

Please return this form to parents

For Office Use Only

Inattention 1-9: ________/9 Hyp-Imp 10-18: ________/9 ODD 19-26: ________/8 Dep / Anx 27-33: ________/7

Academic Strengths: Academic Weakness:

Provider Initials:________________