

Today's date: _____ Child's Name: _____ Date of Birth: _____ Parent's Name: _____

Each rating should be considered in the context of what is appropriate for the age of your child.

Is this evaluation based on a time when the child was on medication was not on medication?

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 misunderstanding)	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/her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

PERFORMANCE

	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall School Performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (e.g., teams)	1	2	3	4	5

-Please Turn Over-

Today's date: _____ Child's Name: _____ Date of Birth: _____ Parent's Name: _____

SEVERITY OF IMPAIRMENT:

Considering your total experience with this child, how severely impaired is he/she at this time? Compare this child to average normal children you are familiar with from your totality of experience. Please circle the number that best describes this child.

NORMAL, NO IMPAIRMENT 1	Symptoms are not present any more than expected (of a typical child of the same age and gender in the same situations) and do not produce impairment of normal functioning at home or at school.
SLIGHT IMPAIRMENT 2	Symptoms are present a little more frequently or intensely than expected (of a typical child of the same age and gender in the same situations) and only rarely produce impairment of normal functioning at home or school.
MILD IMPAIRMENT 3	Symptoms are present somewhat more frequently or intensely than expected (of a child of the same age and gender in the same situations) and only sometimes produce impairment of normal functioning at home or school.
MODERATE IMPAIRMENT 4	Symptoms are present a lot more frequently or intensely than expected (of a child of the same age and gender in the same situations) and usually produce impairment of normal functioning at home or school.
SEVERE IMPAIRMENT 5	Symptoms are present a great deal more frequently or intensely than expected (of a child of the same age and gender in the same situations) and most of the time produce impairment of normal functioning at home or school.
VERY SEVERE IMPAIRMENT 6	Symptoms are present so much more frequently or intensely than expected (of a child of the same age and gender in the same situations) that they almost always produce impairment of normal functioning at home or school.
MAXIMAL, PROFOUND IMPAIRMENT 7	Symptoms are present so frequently or intensely that they produce significant and pervasive impairment, which creates a crisis requiring immediate action to prevent serious deterioration, to avoid danger, or to prevent harm.

Pittsburgh Side-Effects Rating Scale

Instructions: Listed below are several possible negative effects (side effects) that medication may have on an ADHD child. Please read each item carefully and use the boxes to rate the severity of this child's side effects during your contact with him or her today. When requested, or wherever you feel it would be useful for us to know, please describe the side effects that you observed or any other unusual behaviors in the "Comments" section below. The same person should complete this scale each time it is completed.

Use the following to assess severity:

None: The symptom is assessed and is found absent

Mild: The symptom is present but is not sufficient to cause concern to the child, peers or adults and would not affect a decision to recommend medication.

Moderate: The symptom causes impairment of functioning or social embarrassment to a degree that the benefits of medication must be considerable to justify the risks of continuing medication.

Severe: The symptom causes impairment of functioning or social embarrassment to a degree that the child should not continue to receive medication as part of treatment.

	None	Mild	Moderate	Severe
Motor Tics—repetitive movements: jerking or twitching (e.g., eye blinking-eye opening, facial or mouth twitching, shoulder or arm movements)—please describe below				
Buccal-lingual movements: Tongue thrusts, jaw clenching, chewing movement besides lip/cheek biting—please describe below				
Picking at skin or fingers, nail biting, lip or cheek chewing—please describe below				
Worried/Anxious				
Dull, tired, listless				
Headaches				
Stomachache				
Crabby, Irritable				
Tearful, sad, depressed				
Socially withdrawn—decreased interaction with others				
Hallucinations (sees or hears things that aren't there)				
Loss of appetite				
Trouble sleeping (time went to sleep)				

Comments: