

CLINICIAN TOOLS



ADHD



Vanderbilt Assessment Scale: ADHD Toolkit Teacher-Informant Form

Child's name: _____ Teacher's name: _____

Today's date: _____ School: _____ Gr: _____ Teacher's fax number: _____

Time of day you work with child: _____

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 behaviors of the school year. **Please indicate the number of weeks or months you have been able to evaluate the behaviors:** _____

This evaluation is based on a time when the child: Was on medication Was not on medication Not sure

Behavior	Never (0)	Occasionally (1)	Often (2)	Very Often (3)
1. Does not give attention to details or makes mistakes that seem careless in schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has difficulty sustaining attention on tasks or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does not seem to listen when spoken to directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does not follow through on instructions and does not finish schoolwork (not because of refusal or lack of comprehension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has difficulty organizing tasks and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Avoids, dislikes, or does not want to start tasks that require sustained mental effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Loses things necessary for tasks or activities (eg, school assignments, pencils, books)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is easily distracted by extraneous stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is forgetful in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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10. Fidgets with hands or feet or squirms in seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Leaves seat when remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Runs about or climbs too much when remaining seated is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has difficulty playing or beginning quiet games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Is on the go or often acts as if "driven by a motor"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Talks excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Blurts out answers before questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has difficulty waiting his or her turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Interrupts or intrudes on others' conversations or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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by Washington University School of Medicine, Christine Chen

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Child's name: _____ Today's date: _____

Behavior	Never (0)	Occasionally (1)	Often (2)	Very Often (3)
19. Loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Actively defies or refuses to adhere to adult's requests or rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Is angry or resentful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Is spiteful and vindictive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Bullies, threatens, or intimidates others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Initiates physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Lies to get out of trouble or to avoid obligations (ie, cons others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Is physically cruel to people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Has stolen things of nontrivial value	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Deliberately destroys others' property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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29. Is fearful, anxious, or worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Is self-conscious or easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Is afraid to try new things for fear of making mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Feels worthless or inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Blames self for problems or feels guilty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Feels lonely, unwanted, or unloved; often says that no one loves him or her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Is sad, unhappy, or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Academic and Social Performance	Excellent (1)	Above Average (2)	Average (3)	Somewhat of a Problem (4)	Problematic (5)
36. Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Mathematics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Relationship with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Following directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Disrupting class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Assignment completion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Organizational skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Child's name: _____ Today's date: _____

Tic behaviors: To the best of your knowledge, please indicate if the child displays the following behaviors:

- 1. Motor tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, and rapid kicks.
 - No tics present.
 - Yes, they occur nearly every day but go unnoticed by most people.
 - Yes, noticeable tics occur nearly every day.
- 2. Phonic (vocal) tics:** Repetitive noises including, but not limited to, throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, and repetition of words or short phrases.
 - No tics present.
 - Yes, they occur nearly every day but go unnoticed by most people.
 - Yes, noticeable tics occur nearly every day.
- 3. If YES to 1 or 2, do these tics interfere with the child's activities (eg, reading, writing, walking, talking, eating)?**
 - No Yes

Previous diagnosis and treatment: Please answer the following questions to the best of your knowledge:

- Has the child been diagnosed as having ADHD or ADD?
 - No Yes
- Is he or she on medication for ADHD or ADD?
 - No Yes
- Has the child been diagnosed as having a tic disorder or Tourette syndrome?
 - No Yes
- Is he or she on medication for a tic disorder or Tourette disorder?
 - No Yes

Adapted from the Vanderbilt rating scales developed by Mark L. Wolraich, MD.

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Total number of questions scored 2 or 3 in questions 1–9: _____ 0 _____

Total number of questions scored 2 or 3 in questions 10–18: _____ 0 _____

Total number of questions scored 2 or 3 in questions 19–28: _____ 0 _____

Total number of questions scored 2 or 3 in questions 29–35: _____ 0 _____

Total number of questions scored 4 in questions 36–43: _____ 0 _____

Total number of questions scored 5 in questions 36–43: _____ 0 _____

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The recommendations in this resource do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original resource included as part of *Caring for Children With ADHD: A Practical Resource Toolkit for Clinicians*, 3rd Edition.

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