Mesa Pediatrics
Professional Association

www.mesapeds.com

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6301 S. McClintock Dr., Ste. 101
Tempe, Arizona 85283-3246
Office 480-831-6800
Fax 480-897-2799
Administration 480-214-2300
Administration Fax 480-214-2301

Billing Office
2222 S. Dobson Rd., Ste. 402
Mesa, Arizona 85202-6457
480-820-7518
Fax 480-820-7573

Chandler Office
60 S. Kyrene Rd., Ste. 1
Chandler, Arizona 85226
480-785-8700
Fax 480-785-8787

Gilbert Office
2550 E. Guadalupe Rd., Ste. 115
Gilbert, Arizona 85234
480-632-1544
Fax 480-632-1533

San Tan Office
3592 S. Atherton Blvd., Ste. 101
Gilbert, Arizona 85297
480-214-2170
Fax 480-214-2171

BEHAVIOR VISIT INFORMATION PACKET

ELEMENTARY SCHOOL

Dear Parent:

You have recently called Mesa Pediatrics ________________________ office to set up an appointment for your child to be evaluated for behavior problems or school failure/underachievement. In order to evaluate your child, Dr. _____________________, who your child is scheduled to see, will need to have the enclosed documents completed prior to their appointment.

To be completed by Parent:

Vanderbilt Assessment Scale – Parent
Behavior Visit Assessment Package

To be completed by your child's Teacher:

Vanderbilt Assessment Scale – Teacher

Please return the documents to Mesa Pediatrics by ________________________ for your child's appointment on _____________ at the following address:

____

____

____

Thank you,

Mesa Pediatrics

John K. Kerr, M.D., F.A.A.P., Emeritus
Albert M. Schwartz, M.D., F.A.A.P.
Joseph Piacentine, M.D., F.A.A.P.
Delphis C. Richardson, M.D., F.A.A.P.
James J. Smith, M.D., F.A.A.P.
Angela T. Wong, M.D., F.A.A.P.
Robin R. Laks, M.D., F.A.A.P.
Susan Chung, M.D., F.A.A.P.
Jennifer L. Wallace, M.D., F.A.A.P.
Kristin McCleland, M.D., F.A.A.P.
Aleta DaSilva, M.D., F.A.A.P.
Andrea DeMets, M.D., F.A.A.P.
Angela Zankich, M.D., F.A.A.P.
Darcey Winterland, M.D., F.A.A.P.
Molly (Margaret) Haley, M.D., F.A.A.P.
Reyna Cuellar, M.D., F.A.A.P.
Michelle C. Valenzuela, M.D., F.A.A.P.
Nicolle Kent, M.D., F.R.C.P.C., F.A.A.P.
Billie (Dawn) Bigham, R.N., M.S.N., P.N.P.-C.
Jennifer L. Gibler, P.A.-C.
William B. Gause, P.A.-C.
Buffy (Elizabeth) Patterson, P.A.-C.

D3 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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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

Revised - 1102

American Academy of Pediatrics

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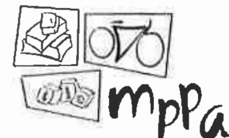
NICHQ

National Initiative for Children's Healthcare Quality



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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: ___________

D4 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

The recommendations in this publication 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.

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

Revised - 0303

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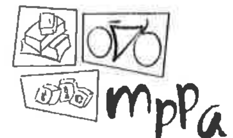

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Teacher's Name: ______________________ Class Time: ______________ Class Name/Period: __________

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: __________

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11-20/rev0303

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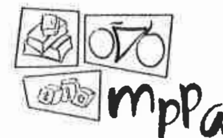

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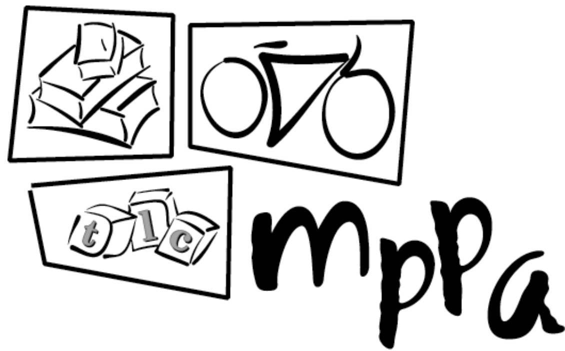

Mesa Pediatrics
Professional Association

Behavior Visit Information Packet

To be completed before visit

Revised 1/2016

This questionnaire asks you a series of questions about you and your family. The information is essential for making an accurate diagnosis. Please complete this form as best you can. We will be able to discuss it in detail at your child's appointment.

Please select or write in your answer for all of the questions.

PLEASE PRINT

INDENTIFYING INFORMATION		
Child's Name	Birth Date	Age
Person Completing Form	Your Relationship to Child	Today's Date
Mother's Name		
Work Phone	Home Phone	Cell Phone
Address		
Father's Name		
Work Phone	Home Phone	Cell Phone
Address		
Circle which applies: biological adopted step foster other _______		
If adopted, how old was the child when he/she was adopted? When did the adoption occur?		
Are you the child's legal guardian? Yes No If no, please explain.		
Name of Guardian		
Work Phone	Home Phone	Cell Phone
Address		

CURRENT CONCERNS

Question	No	Yes
What are your concerns about this child? What are the difficulties/ problems that have caused you to seek help at this time?		
Do you see this child as being hyperactive or as having problems with attention and concentration? If yes, please explain.	☐No	☐Yes
Do you believe this child is able to exert control over behavior, attention and concentration? Please explain.	☐No	☐Yes
Do you see this child as having depression, anxiety, or other mood/behavior issues?	☐No	☐Yes
Has this child ever been diagnosed by a school psychologist or other professional (e.g., mental health clinician/physician) as having ADHD, depression, anxiety or other mood or behavioral conditions? If yes, please explain.	☐No	☐Yes
Has this child received treatment for ADHD? If yes, please explain.	☐No	☐Yes
Has this child received treatment for depression? If yes, please explain.	☐No	☐Yes

Has this child received treatment for any behavioral conditions? If yes, please explain.	☐No ☐Yes
Does this child snore loudly and wake up at night as if gasping? If yes, please explain.	☐No ☐Yes
Is this child on any kind of medication for ADHD, depression, anxiety, mood disorder, or other behavior problem? Please list the name of the medication and dosage the child is given each day. How long has this child been on medication? Has this child had any problems while on medication?	☐No ☐Yes
OTHER CONCERNS YOU MIGHT HAVE:	
Do you have any other concerns about this child's behavior, school performance, emotional well-being, or social life? If yes, please explain.	☐No ☐Yes

Pediatric Symptom Checklist

Please mark under the heading that best fits your child:

	Never	Sometimes	Often
1. Complains of aches/pains....................	☐	☐	☐
2. Spends more time alone......................	☐	☐	☐
3. Tires easily, little energy.................	☐	☐	☐
4. Fidgety, unable to sit......................	☐	☐	☐
5. Has trouble with a teacher..................	☐	☐	☐
6. Less interested in school...................	☐	☐	☐
7. Acts as if driven by a motor................	☐	☐	☐
8. Daydreams too much..........................	☐	☐	☐
9. Distracted easily...........................	☐	☐	☐
10. Is afraid of new situations................	☐	☐	☐
11. Feels sad, unhappy.........................	☐	☐	☐
12. Is irritable, angry........................	☐	☐	☐
13. Feels hopeless.............................	☐	☐	☐
14. Has trouble concentrating..................	☐	☐	☐
15. Less interest in friends...................	☐	☐	☐
16. Fights with others.........................	☐	☐	☐
17. Absent from school.........................	☐	☐	☐
18. School grades dropping.....................	☐	☐	☐
19. Is down on him or herself..................	☐	☐	☐
20. Visits Dr. with Dr. finding nothing wrong...	☐	☐	☐
21. Has trouble sleeping.......................	☐	☐	☐
22. Worries a lot..............................	☐	☐	☐
23. Wants to be with you more than before.......	☐	☐	☐
24. Feels he or she is bad.....................	☐	☐	☐
25. Takes unnecessary risks....................	☐	☐	☐
27. Seems to be having less fun................	☐	☐	☐
28. Acts younger than children his or her age...	☐	☐	☐
29. Does not listen to rules...................	☐	☐	☐
30. Does not show feelings.....................	☐	☐	☐
31. Does not understand other people’s feelings.	☐	☐	☐
32. Teases others..............................	☐	☐	☐
33. Blames others for his or her troubles.......	☐	☐	☐
34. Takes things that do not belong to him/her..	☐	☐	☐
35. Refuses to share...........................	☐	☐	☐

Other comments:

FAMILY HISTORY OF PSYCHIATRIC PROBLEMS

Do any other family members (e.g., mother, father, brother, sister, aunt, uncle, etc.) suffer from a similar problem with inattentiveness/ hyperactivity, or some other type of psychological, emotional, learning problem, and/or nervous disorder, etc.? ☐No ☐Yes

Family Member's Relationship to Child	Current Age	Type of Problem	Severity? e.g., mild, severe	Type of Treatment

CHILD'S EDUCATIONAL HISTORY

Name of School	School District	Grade

Type of Classroom Placement (e.g., regular, Emotionally Disturbed/ Learning Disabled, Resource Room. Etc.)

Approximately how many children are in this child's class?

Check all those official school classifications that apply to this child:

☐ Learning Disabled

☐ Visually Impaired

☐ Emotionally Disturbed

☐ Hearing Impaired

☐ Mentally Retarded/Intellectually Limited

☐ Physically Handicapped

☐ Other

Teacher's Name	Resource Teacher's Name
Principal's Name	School Psychologist and/or Counselor's Name

The name(s), addresses, and phone numbers of any other person involved in this child's education that you feel we should contact.

Did this child attend any type of preschool program? ☐No ☐Yes

If yes, what type of program, at what age did he/she begin, and how frequently did he/she attend (e.g., nursery school – for example: age 4, 2X/week/2 hr. session)?

Question		
Did this child have any problems in preschool? If yes, please describe.	☐No	☐Yes
Did this child repeat any grades? If yes, which ones and what was the reason for repeating that particular grade?	☐No	☐Yes
Did this child fail any subjects? If yes, which ones?	☐No	☐Yes
Does this child currently receive any special education Services? If yes, specify type (e.g., self-contained class, resource room, reading or math lab, etc.). Frequency of attendance in special classes (e.g., full-time Placement, 1X/day-30 min. session).	☐No	☐Yes
Please list or discuss any other school problems.		

INFANCY AND EARLY CHILDHOOD

Check all that apply. If you mark "yes," please explain.

Item		
Colicky	☐No	☐Yes
Feeding Problems	☐No	☐Yes
Sleeping Problems	☐No	☐Yes
Restless	☐No	☐Yes
Active	☐No	☐Yes
Did not enjoy cuddling	☐No	☐Yes
Head banging	☐No	☐Yes
Accident-prone	☐No	☐Yes
Uncoordinated	☐No	☐Yes
Poor eye contact	☐No	☐Yes
No social smile	☐No	☐Yes
Preferred to be left alone	☐No	☐Yes
Did not like new situations	☐No	☐Yes
Poorly attached	☐No	☐Yes
Separation anxiety	☐No	☐Yes
Unusual fear of strangers	☐No	☐Yes
Unusually shy or withdrawn	☐No	☐Yes
Excessive anxiety or fears	☐No	☐Yes
Easily over stimulated	☐No	☐Yes

Are there other problems or comments regarding this child's infancy and early childhood development? Please describe.

Childs's approximate age when he/she began:

walking _______ months

talking _______ years

talking (short sentences -- 2+ words) ________ years

toilet training: daytime ________ years

nighttime ________ years

Overall, do you feel this child developed at a rate? Please explain. ☐slow ☐normal ☐rapid

What expectations/goals do you have for this visit?