

ADHD Assessment Scale (Follow Up) – 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. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her 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. Doesn't 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. Doesn't seem to listen when spoken to	0	1	2	3
4. Doesn't follow through when given directions and fails to finish activities (not due to refusal or not understanding)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or doesn't want to begin tasks that require ongoing mental effort	0	1	2	3
7. Loses thing 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 around 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

ADHD Assessment Scale (Follow Up) – Parent Informant (continued)

Today’s Date: _____
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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 (eg, teams)	1	2	3	4	5

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite- explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening- explain below				
Socially withdrawn- decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking- explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing- explain below				
Sees or hears things that aren’t there				

Explain/Comments:

For Office Use Only	Scores		
	Date/Medication	Date/Medication	Date/Medication
Total Symptom Score for questions 1-18			
Average Performance Score for questions 19-26			