



5425 Lanark Road Suite 200  
Center Valley, PA 18034  
Phone: 484-658-5437 Fax: 833-214-7525  
Email: DevPeds@sluhn.org

**New Patient Intake Form**

**Demographics**

Date: \_\_\_\_\_  
Child's Legal Name: \_\_\_\_\_ Childs Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex assigned at birth: \_\_\_\_\_  
Preferred Language: \_\_\_\_\_ Written Language: \_\_\_\_\_ Interpreter Needed? \_\_\_\_\_  
Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Religion: \_\_\_\_\_  
Child's Address: \_\_\_\_\_ County: \_\_\_\_\_  
Primary Phone number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_  
Email Address: 1. \_\_\_\_\_ 2. \_\_\_\_\_

**Who are the Legal Guardian(s) of the child?:**

Mother  Father  Other (please specify): \_\_\_\_\_

Parent/Guardian Marital Status :  Married  Divorced  Separated  Never Married  Widowed

**Are there any custody issues or orders of protection of which we should be aware? (Copy of court orders required- send copy to office)**  Yes\*  No

**Parent/Guardian 1:**

Last name \_\_\_\_\_ First Name \_\_\_\_\_ DOB: \_\_\_\_\_

Highest School Level Completed: \_\_\_\_\_

Employed:  Full-Time  Part-Time  Other; Employers Name: \_\_\_\_\_

**Parent/Guardian 2:**

Last name \_\_\_\_\_ First Name \_\_\_\_\_ DOB: \_\_\_\_\_

Highest School Level Completed: \_\_\_\_\_

Employed:  Full-Time  Part-Time  Other; Employers Name: \_\_\_\_\_

### Family Composition

Please check those with whom the child lives (Write in names):

- |   |   |
|---|---|
| <input type="checkbox"/> Biological Mother: _____                 | <input type="checkbox"/> Biological Father: _____ |
| <input type="checkbox"/> Step-Mother: _____                       | <input type="checkbox"/> Step-Father: _____       |
| <input type="checkbox"/> Adoptive Mother: _____                   | <input type="checkbox"/> Adoptive Father: _____   |
| <input type="checkbox"/> Grandmother: _____                       | <input type="checkbox"/> Grandfather: _____       |
| <input type="checkbox"/> Guardian(s): _____                       | <input type="checkbox"/> Other(s): _____          |
| <input type="checkbox"/> Siblings (specify half/step/full): _____ |   |

### Biologic Family Medical and Psychiatric History

Does anyone in this child's biologic family have:	Yes	No	Relationship to the child? Please specify maternal or paternal (i.e paternal uncle)
ADHD/ADD or Attentional Issues			
Alcohol or Drug Abuse			
Arrhythmia or heart problems before age 50- <b>if yes, specify</b>			
Autism Spectrum Disorder			
Behavior Problems or Trouble with the law			
Birth Defects			
Developmental Delays (late walker/talker)			
Diabetes			
Emotional, Physical, or Sexual Abuse			
Genetic Diagnosis			
Hearing Loss or Vision Loss (glasses)			
Intellectual Disability (formerly mental retardation)			
Learning Difficulties or disability (reading, writing, math, etc.)			
Obesity			
Mental health disorders such as anxiety, depression, obsessive compulsive disorder, bipolar, schizophrenia- <b>if yes, specify</b>			
Seizures/epilepsy			
Sudden Death before Age 50			
Tics/Tourette's Syndrome			
Other Conditions/Diagnoses – <b>specify</b>			

Pregnancy and Newborn History			
	Yes	No	Comment
Age of mother when child was born ____ years			
Baby was born at ____ weeks			
Birth weight? ____Lbs. ____oz.			
Is this child a twin or triplet?	<input type="checkbox"/>	<input type="checkbox"/>	
Any problems with other pregnancies? Miscarriages?	<input type="checkbox"/>	<input type="checkbox"/>	
Used <i>in vitro fertilization</i> or other method of conception?	<input type="checkbox"/>	<input type="checkbox"/>	
Were there any problems during <i>this</i> pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Were any medications prescribed during pregnancy? Why?	<input type="checkbox"/>	<input type="checkbox"/>	
Did mother have gestational diabetes (sugar in urine), high blood pressure, toxemia, or infections (including herpes) during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Any smoking, alcohol consumed (beer, wine, etc.), or street drugs (marijuana, cocaine, etc.) used during pregnancy? (	<input type="checkbox"/>	<input type="checkbox"/>	
Any problems during labor or delivery?	<input type="checkbox"/>	<input type="checkbox"/>	
Cesarean delivery? Why?	<input type="checkbox"/>	<input type="checkbox"/>	
Were there any problems at birth or as a newborn?	<input type="checkbox"/>	<input type="checkbox"/>	
Were there any birth defects or birth injuries noted?	<input type="checkbox"/>	<input type="checkbox"/>	
Did baby have jaundice and need phototherapy?	<input type="checkbox"/>	<input type="checkbox"/>	
Was baby very jittery or lethargic as a newborn?	<input type="checkbox"/>	<input type="checkbox"/>	
Did baby have to stay extra days in the hospital/NICU? *If yes how many days? ____	<input type="checkbox"/>	<input type="checkbox"/>	

Infant Temperament			
As an infant/toddler did your child have any of the following?			
	Yes	No	Comment
Feeding difficulties	<input type="checkbox"/>	<input type="checkbox"/>	
Prolonged colic or excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	
Extreme irritability	<input type="checkbox"/>	<input type="checkbox"/>	
A loose or floppy body	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive body movements (wiggly or active)	<input type="checkbox"/>	<input type="checkbox"/>	
Easily over-stimulated	<input type="checkbox"/>	<input type="checkbox"/>	
Was shy or withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	
A dislike of being held or cuddled	<input type="checkbox"/>	<input type="checkbox"/>	

Development History		
	Approximate Age Accomplished	Too Young
Sat without support		<input type="checkbox"/>
Walked without support		<input type="checkbox"/>
Spoke first words (except mama/dada)		<input type="checkbox"/>
Spoke in two-three word sentences		<input type="checkbox"/>
Toilet trained during the day		<input type="checkbox"/>
Dry at night		<input type="checkbox"/>
Able to dress self		<input type="checkbox"/>
Rode a tricycle		<input type="checkbox"/>
Read simple words		<input type="checkbox"/>
Able to tie shoes		<input type="checkbox"/>
Has your child ever had a regression in skills (loss of previously acquired skills) outside of those that occur during breaks from school? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please explain.</b>		

Current or Past Medical Symptoms			
Has your child ever had, or do they currently have, any of the following medical problems?			
	Yes	No	Comments
Serious illness or infection	<input type="checkbox"/>	<input type="checkbox"/>	
Serious injury, (burns, broken bones, concussion, needed stitches, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal growth (too small/too large)	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures, staring spells, convulsions	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent headaches/ fainting/ dizzy episodes	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems or arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	
Unexplained vomiting or reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Unusual reaction to immunizations	<input type="checkbox"/>	<input type="checkbox"/>	
Are immunizations up to date	<input type="checkbox"/>	<input type="checkbox"/>	
Known genetic problems	<input type="checkbox"/>	<input type="checkbox"/>	
Low tone or spasticity (rigid/stiff body)	<input type="checkbox"/>	<input type="checkbox"/>	
Birth marks or skin problems	<input type="checkbox"/>	<input type="checkbox"/>	
Tooth issues or cavities	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulties with bowel movements (constipation, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	
Daytime urinary incontinence ('wets' pants)	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal movements	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid or hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent ear infections and/or tubes?	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble with vision? (eye glasses)	<input type="checkbox"/>	<input type="checkbox"/>	
Other specific diagnosis, <b>please specify</b>	<input type="checkbox"/>	<input type="checkbox"/>	

### Reason for Visit

How old was your child when concerns began? \_\_\_\_\_

Parental Concerns
What are your top 3 concerns regarding your child?
1.
2.
3.
What are your child's top 3 strengths?
1.
2.
3.

Professional Evaluations					
Has your child previously been evaluated by any of the following providers? (Please check all that apply and <b>provide copies of reports</b> ):					
	Previous Evaluations		Provider Name	Evaluation Date	Diagnosis
Developmental Pediatrician (CHOP, LVPG, Geisinger, Hershey, other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Neurologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Psychiatrist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Psychologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Speech Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Occupational Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Physical Therapist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Behavior Therapist (KidsPeace, Pine Brook, Progressions, PA Mentor, Access, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Other Specialists (Gastroenterology, Pulmonology, Vision, ENT, Audiology, Cardiology, Endocrine Orthopedics, Orthotics etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Mental Health Counselor	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Genetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Other (Black Bird, Easter Seals, Meliora, Glenn Koch)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Medication History					
Is your child currently taking, or have they previously taken, any supplements or medications for <i>inattention, anxiety, behavior, mood or sleep</i> ?				<input type="checkbox"/> Yes*	<input type="checkbox"/> No
*If yes, please list <b>all medications and supplements</b> your child is <b>currently taking or has tried</b>					
Name of Medication	Reason for taking	Dosage	Frequency	Period taken	Prescribed by whom?
Are you seeking consultation for medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Medical History			
Has your child had any previous medical testing completed including, but not limited to, EEG, MRI, CT scan, EKG, genetic or metabolic testing, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Year	Type of Testing	Where was it done?	Results
<b>Lead Testing</b>			
Any history of elevated lead level? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, peak level _____ Date: _____			
<b>Hearing Testing</b>			
Passed newborn hearing screen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has child passed hearing screens through doctor or school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has formal hearing testing even been done at speech/hearing center or ENT? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, date done: _____			

Hospitalizations/Surgical History		
Has your child had any previous hospitalizations or surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*if yes, specify below		
Date	Reason	Location

Sleep History and Screen Time			
	Yes	No	Comments
Where does your child sleep?			
Does your child have trouble falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have trouble staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have any night terrors or sleep walking?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child snore?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a TV in the bedroom and/or does your child have screentime within two hours of sleep	<input type="checkbox"/>	<input type="checkbox"/>	
How many hours per day does your child use electronic devices with screens (cellphone, tv, tablet, computer, video games, etc)			

Nutrition/Diet			
	Yes	No	Comments
Any history of or current feeding/eating difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the child eat from all food groups (meat/protein, dairy, complex carbohydrates, fruits, vegetables)?	<input type="checkbox"/>	<input type="checkbox"/>	
Any special dietary modifications?	<input type="checkbox"/>	<input type="checkbox"/>	
Takes any vitamins or supplements?	<input type="checkbox"/>	<input type="checkbox"/>	
Please indicate the types of foods that your child currently consumes (select all that apply): <input type="checkbox"/> Bottle fed <input type="checkbox"/> Soft Foods <input type="checkbox"/> Crunchy or textured foods <input type="checkbox"/> Pureed Foods <input type="checkbox"/> Table food/solids			

Safety			
	Yes	No	Please explain
Does child place non-food items in mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
Does child wander/elope?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the home child-proofed?	<input type="checkbox"/>	<input type="checkbox"/>	
Does anyone smoke or use e-cigarettes in the home (including basement) or car?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there any guns in the home?	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Are the guns stored in a locked place?</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Are bullets stored separately from guns?</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the child exposed to yelling or physical violence in the home?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the child ever experienced abuse (emotional, physical, and/or sexual)?	<input type="checkbox"/>	<input type="checkbox"/>	

Tantrums and Behavior Management			
	Yes	No	Comments
Does your child have frequent tantrums (e.g., emotional outbursts that range from yelling to aggression)	<input type="checkbox"/>	<input type="checkbox"/>	
How many tantrums per day? _____ Per week? _____			
How long do tantrums last on average? _____ mins How long do tantrums last at their worst? _____ mins			
Common triggers:			
What helps your child to calm?			
Have you tried any of the following?: Time Out <input type="checkbox"/> Ignoring <input type="checkbox"/> Redirection <input type="checkbox"/> Earning Privileges <input type="checkbox"/> Taking away privileges <input type="checkbox"/> Yelling <input type="checkbox"/> Spanking <input type="checkbox"/> Giving more chores <input type="checkbox"/>			

Learning and Behavioral Symptoms			
<b>My Child is Able To (select all that apply):</b>			
Speak clearly	<input type="checkbox"/>	Understand jokes and sarcasm (be silly)	<input type="checkbox"/>
Write legibly, draw	<input type="checkbox"/>	Self-sooth or be consoled	<input type="checkbox"/>
Run and move around easily	<input type="checkbox"/>	Be empathetic/kind to others	<input type="checkbox"/>
Dress and feed themselves	<input type="checkbox"/>	Play with other children/make friends	<input type="checkbox"/>
Understand social cues/body language	<input type="checkbox"/>	None of the above	<input type="checkbox"/>
Comment:			
<b>My Child Can Be Described As (select all that apply):</b>			
Anxious	<input type="checkbox"/>	Generally calm	<input type="checkbox"/>
Hyperactive & Impulsive	<input type="checkbox"/>	Sensitive to sensory input (sights, smells, touch, sounds)	<input type="checkbox"/>
Emotionally reactive	<input type="checkbox"/>	Strong-willed	<input type="checkbox"/>
Moody or depressed	<input type="checkbox"/>	Inattentive	<input type="checkbox"/>
Shy or slow-to-warm up	<input type="checkbox"/>	Mostly pleasant	<input type="checkbox"/>
Persistent & Demanding	<input type="checkbox"/>	None of the above	<input type="checkbox"/>
Comment:			
<b>My Child Shows an Understanding of (select all that apply):</b>			
Shapes	<input type="checkbox"/>	Letters	<input type="checkbox"/>
Colors	<input type="checkbox"/>	Reading	<input type="checkbox"/>
Numbers	<input type="checkbox"/>	Writing (not fine motor issues)	<input type="checkbox"/>
Counting	<input type="checkbox"/>	Math	<input type="checkbox"/>
None of the above	<input type="checkbox"/>	Comment:	

<b>My Child Has Difficulty With (select all that apply):</b>	
Paying attention to people talking <input type="checkbox"/>	Change in routine <input type="checkbox"/>
Holding a conversation <input type="checkbox"/>	Responding to their name <input type="checkbox"/>
Understanding tone of voice <input type="checkbox"/>	None of the above <input type="checkbox"/>
Using eye contact <input type="checkbox"/>	Comment:
<b>I Have Concerns for My Child's (select all that apply):</b>	
Understanding of spoken words <input type="checkbox"/>	Unnecessarily organizing <input type="checkbox"/>
Ability to retain information <input type="checkbox"/>	Repetitive behaviors/actions <input type="checkbox"/>
Self-injurious behaviors (hitting/biting/scratching/head banging) <input type="checkbox"/>	Ability to play with toys, sharing, taking turns (using toys appropriately/imaginative play) <input type="checkbox"/>
Ability to communicate with words or gestures <input type="checkbox"/>	Ability to make friends <input type="checkbox"/>
Poor self esteem <input type="checkbox"/>	Literal or concrete thinking <input type="checkbox"/>
Use of odd language <input type="checkbox"/>	Abnormal reaction to pain <input type="checkbox"/>
None of the above <input type="checkbox"/>	Comment:
<b>My Child is Frequently (select all that apply):</b>	
Repeating words/phrases previously heard <input type="checkbox"/>	<input type="checkbox"/>
Focused on unusual topics or items <input type="checkbox"/>	Collecting odd items <input type="checkbox"/>
Making negative comments <input type="checkbox"/>	Refusing to go to school <input type="checkbox"/>
Refusing/struggling to complete school work <input type="checkbox"/>	Talking about hurting themselves or others <input type="checkbox"/>
Comment:	

School Information (Grades K-12)			
Name of Current School:			
Current School District:			
How is your child doing in school?			
Has your child ever been expelled or suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe the circumstances:			
Before or after school daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Daycare:			
Has your child ever been evaluated by the following?:			Age at Evaluation
Early intervention	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Intermediate Unit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
School District	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does your child have any of the following plans in school?			
*Copy of reports required*			
<input type="checkbox"/> 504 Plan	<input type="checkbox"/> IEP (Individual Education Plan)	<input type="checkbox"/> Behavior Intervention Plan	
Does your child currently receive any of the following support services in school?			
Please check all that apply:			
<input type="checkbox"/> 1:1 Aide or paraprofessional	<input type="checkbox"/> Special Instruction		
<input type="checkbox"/> English as a Second Language (ESSL)	<input type="checkbox"/> Speech Therapy		
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Behavioral supports: wrap around services, provider 50, BHRS/IBHS (BCBA/BHT/RT/MT)	<input type="checkbox"/> Learning Support		
<input type="checkbox"/> Teacher of the Deaf (TOF)	<input type="checkbox"/> Teacher of the visually impaired (TOVI)		
<input type="checkbox"/> Other (specify):			

**Home Situations Questionnaire**  
St. Luke's Developmental Pediatrics

**Instructions:** Does your child present any problems with compliance to instruction, comments, or rules for you in any of these situations? If so, please circle the word YES and then circle a number beside that situation that describes how severe the problem is for you. If your child is not a problem in a situation, circle NO and go to the next situation on the form.

Situation	Problem Present?		How Severe?								
			Mild			Moderate			Severe		
	No	Yes	1	2	3	4	5	6	7	8	9
Playing Alone	No	Yes	1	2	3	4	5	6	7	8	9
Playing with other children	No	Yes	1	2	3	4	5	6	7	8	9
Meal times	No	Yes	1	2	3	4	5	6	7	8	9
Getting dressed/undressed	No	Yes	1	2	3	4	5	6	7	8	9
Washing and bathing	No	Yes	1	2	3	4	5	6	7	8	9
When you are on the telephone	No	Yes	1	2	3	4	5	6	7	8	9
When visitors are in your home	No	Yes	1	2	3	4	5	6	7	8	9
When you are visiting someone's home	No	Yes	1	2	3	4	5	6	7	8	9
In public places	No	Yes	1	2	3	4	5	6	7	8	9
When father is home ( <input type="checkbox"/> check if not applicable)	No	Yes	1	2	3	4	5	6	7	8	9
When asked to do chores	No	Yes	1	2	3	4	5	6	7	8	9
When asked to do homework	No	Yes	1	2	3	4	5	6	7	8	9
At bedtime	No	Yes	1	2	3	4	5	6	7	8	9
When with a babysitter	No	Yes	1	2	3	4	5	6	7	8	9

## 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



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality



## NICHQ Vanderbilt Assessment Scale—PARENT Informant

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: \_\_\_\_\_

St. Luke's Developmental Pediatrics  
 5425 Lanark Road Suite 200  
 Center Valley, PA 18034  
 Fax: 833-214-7525  
 Email: Devped@sluhn.org

