

FOLLOW UP TEACHER / SCHOOL QUESTIONNAIRE: Attention Deficit Hyperactivity Disorder & Learning



Please answer these questions to the best of your ability and fax both sides of this form to this child's Medical Provider below. **THANK YOU!**

Medical Provider's Name & Fax Number: _____

Child's Name & [Sponsors] Social:	Grade:	Today's Date:
School:	Teacher's Name:	Time of class:

1. BEHAVIORS: <i>Check the box that best describes this child's behavior over the last week or so.</i>	Are these behaviors currently a problem?			
	Never/Rarely	Occasionally	Often	Very Often
Fails to give close attention to details or makes careless mistakes in schoolwork.				
Has difficulty sustaining attention in tasks or activities.				
Does not listen when spoken to directly.				
Does not follow through on instructions and fails to finish schoolwork.				
Has difficulties organizing tasks and activities.				
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.				
Loses things necessary for tasks or activities.				
Is easily distracted by extraneous stimuli.				
Is forgetful in daily activities.				
Fidgets with hands or feet or squirms in seat.				
Leaves seat in classroom or in other situations in which remaining seated is expected.				
Runs about or climbs excessively in situations in which remaining seated is expected.				
Has difficulty playing or engaging in leisure activities quietly.				
Is "on the go" or acts as if "driven by a motor."				
Talks excessively.				
Blurts out answers before questions have been completed.				
Has difficulty waiting in line.				
Interrupts or intrudes on others.				

2. PERFORMANCE: <i>Check the box that best describes this child's performance over the last week or so.</i>	Are these activities currently a problem?				
	Above Average	Average	Problematic		
	1	2	3	4	5
Classroom assignment completion					
Organizational skills					
Getting homework to and from school					
Homework completion					
Relationship with peers					
Following directions					
Disrupting class					
Reading					
Mathematics					
Written expression					

3. SUMMARY: Please summarize this child's **OVERALL** functioning (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing ONE number below. Compare this child's functioning in 2 settings-- school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number.**

- | | |
|---|--|
| 1 | Excellent functioning / No impairment in settings |
| 2 | Good functioning / Rarely shows impairment in settings |
| 3 | Mild difficulty in functioning / Sometimes shows impairment in settings |
| 4 | Moderate difficulty in functioning / Usually shows impairment in settings |
| 5 | Severe difficulties in functioning / Most of the time shows impairment in settings |
| 6 | Needs considerable supervision in all settings to prevent from hurting self or others |
| 7 | Needs 24-hour professional care and supervision due to severe behavior or gross impairment(s) |

Medical Provider Use ONLY 1-9=Inattentive: ___/9 10-18=Hyperactive: ___/9 Performance [any 'Problematic' needs addressing]: Y N Impairment to Functioning [4 or higher's a problem]: Y N

FOLLOW UP TEACHER / SCHOOL QUESTIONNAIRE (continued)



Child's Name:

4. SIDE EFFECTS: Has this 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 <i>Explain below:</i>				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening <i>Explain below:</i>				
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 <i>Explain below:</i>				
Picking at skin or fingers, nail biting, lip or cheek chewing <i>Explain below:</i>				
Sees or hears things that aren't there				
EXPLAIN/COMMENTS:				

5. Is this child receiving any special assistance (tutoring, after school, special education services) from the school system at this time? If yes, please specify:

6. Are there any PARTICULAR times (PLEASE BE SPECIFIC) when you've noticed this child's behavior is BETTER? Are there any environmental factors that might explain these times? (ie: "The first hour in the morning he seems to really well".)

7. Are there any PARTICULAR times (PLEASE BE SPECIFIC) when you've noticed this child's behavior is WORSE? Are there any environmental factors that might explain these times? (ie: "about 11 AM every day she starts to have trouble sitting still".)

8. When are there natural breaks in the day for this child between 10--12 PM and 1--3 PM?

9. Are there any other comments you would like to share? Please comment:

Medical Provider Use Only	

Provider Signature:

Date: