



Vanderbilt Parent Assessment Scale

Today's Date: _____

Child's Name: _____ DOB: _____ Parent's Name: _____

Each rating should be considered in the context of what is appropriate for the age of your child.

Is this evaluation based on a time when the child Was on medication Was not on medication

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 misunderstanding)	0	1	2	3	
5. Has difficulty organizing task and activities	0	1	2	3	
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental efforts	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	Count # 2s & 3s
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	Count # 2s & 3s
16. Blurts out answers before questions have been completed	0	1	2	3	
17. Has difficulty waiting his/her turn	0	1	2	3	TSS 1-18
18. Interrupts or intrudes in 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' request 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	Count # 2s & 3s
26. Is spiteful and wants to get even	0	1	2	3	

**Email to Mason_PrimaryCare@cchmc.org or
Mail Completed Form to:**

Cincinnati Children's Liberty Primary Care
7335 Yankee Rd., Suite 100
Liberty Township, OH 45044
Phone: 513.336.6700

Cincinnati Children's Mason Primary Care
9600 Children Dr., Bldg. D
Mason, 45040
Phone: 513.336.6700

*****Please Complete the Second Page of This Form*****



Symptoms, continued	Never	Occasionally	Often	Very Often	
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 (i.e., "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	
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	Count # 2s & 3s
40. Has forced someone into sexual activities	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/her"	0	1	2	3	
46. Is sad, unhappy, or depressed	0	1	2	3	Count # 2s & 3s
47. Is self-conscious or easily embarrassed	0	1	2	3	

Impairment	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	Count # 4s & 5s
52. Relationship with parents	1	2	3	4	5	
53. Relationship with siblings	1	2	3	4	5	Count # 48 & 55
54. Relationship with peers	1	2	3	4	5	
55. Participation in organized activities (e.g., teams)	1	2	3	4	5	

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

Pre-Existing Problems

Use the following to assess severity:

None: The symptom is not present.

Mild: The symptom is present but is not significant enough to cause concern to the child, to his/her friends, or adults.

Moderate: The symptom causes some impairment of functioning or social embarrassment.

Severe: The symptom causes impairment of functioning or social embarrassment to such a degree that it requires specific treatment.

	None	Mild	Moderate	Severe
Motor Tics—repetitive movements: jerking or twitching (e.g., eye blinking—eye opening, facial or mouth twitching, shoulder or arm movements) – describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buccal-lingual movements: Tongue thrusts, jaw clenching, chewing movement besides lip/cheek biting – describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picking at skin or fingers, nail biting, lip or cheek chewing – describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried/Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dull, tired, listless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomachache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crabby, Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tearful, Sad, Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socially withdrawn – decreased interaction with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations (see or hear things that aren't there)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble sleeping (time went to sleep)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adapted from Pittsburgh Side-Effects Rating Scale