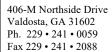
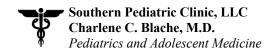


Patient Name:		Date of Birth	Date:
	ADH	D Parent Evaluation I	Form
School Performance	□ □ Notes:		mproving
School Support	□ □ □ Notes:	Well Supported Teachers are very Involved 504 Plan in Place IEP in Place	<ul><li>□ Poor Support</li><li>□ Poor Communication</li><li>□ Teachers are not Involved</li></ul>
Organization	□ Notes:	Good Organization	☐ Poorly Organized
Appetite	□ □ Notes:	Normal Appetite Increased Appetite	<ul><li>☐ Decreased Appetite</li><li>☐ Binge Eating</li></ul>
Mood	□ Notes:	Stable	oile/Emotional
Sleep	□ □ Notes:	Good Adequate Sleep Not Tired at School	<ul><li>☐ Poor Sleep</li><li>☐ Lack of Adequate Sleep</li><li>☐ Tired at School</li></ul>
Friends	□ □ Notes:	Well Connected with Peers None	<ul><li>□ Very Few</li><li>□ Peer Group not Desirable</li></ul>
Family	□ □ Notes:	No new Stressors Not Getting Along	☐ Major Problems
Self Esteem	□ Notes:	High	☐ Low
Attention	□ Notes:	Ability to Focus Day	y Dreams a lot
Hyperactivity	□ □ Notes:	Is not Hyperactive Constantly in Motion Unable to Keep Hands to Self	<ul><li>☐ Excessively Talkative</li><li>☐ Fidgets/Squirms</li></ul>
Impulsivity	□ □ Notes:	Is not Impulsive Does not Think Before Doing	☐ Blurts out Answers ☐ Cannot wait for Turn
Tasking	□ Notes:	Able to Complete Tasks	☐ Unable to Complete Tasks
Current ADHD Medication(s)	):		





## Patient Authorization for Practice to Receive/Release Protected Information To Third Parties (Teachers)

I authorize Southern Pediatric Clinic to disclose and use information regarding my child's progress in school, grades, temperament, and classroom behavior reported from teachers. This information will help with the diagnosis, treatment, and medication management of his/her behavioral health.

Name of Child's School:	
Address:	
City, State, Zip Code:	
Teacher's Name:	
Phone Number:	
Signature of Patient/Parent or Legal Guardian: _ Date:	