Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

Patient Name: _____Date of Birth_____ Date: _____

ADHD Parent Evaluation Form

School Performance	☐ No Issue ☐ Improving ☐ Failing ☐ Child is Learning ☐ Child is not Learning ☐ Struggling Notes:
School Support	☐ Well Supported ☐ Poor Support ☐ Teachers are very Involved ☐ Poor Communication ☐ 504 Plan in Place ☐ Teachers are not Involved ☐ IEP in Place Notes:
Organization	☐ Good Organization ☐ Poorly Organized Notes:
Appetite	☐ Normal Appetite ☐ Decreased Appetite ☐ Increased Appetite ☐ Binge Eating Notes:
Mood	☐ Stable ☐ Labile/Emotional ☐ A Major Concern Notes:
Sleep	☐ Good ☐ Poor Sleep ☐ Adequate Sleep ☐ Lack of Adequate Sleep ☐ Not Tired at School ☐ Tired at School Notes:
Friends	☐ Well Connected with Peers ☐ Very Few ☐ None ☐ Peer Group not Desirable Notes:
Family	☐ No new Stressors ☐ Major Problems ☐ Not Getting Along Notes:
Self Esteem	☐ High ☐ Low Notes:
Attention	☐ Ability to Focus ☐ Day Dreams a lot ☐ Unable to Focus Notes:
Hyperactivity	☐ Is not Hyperactive ☐ Excessively Talkative ☐ Constantly in Motion ☐ Fidgets/Squirms ☐ Unable to Keep Hands to Self Notes:
Impulsivity	☐ Is not Impulsive ☐ Blurts out Answers ☐ Does not Think Before Doing ☐ Cannot wait for Turn Notes:
Tasking	☐ Able to Complete Tasks ☐ Unable to Complete Tasks Notes:
Current ADHD Medication(s): _____	

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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: _____