



# ASSESSMENT: When it might not be ADHD

Clinical scenario	Differential Considerations	What next?
<b>Symptoms only reported in 1 setting</b>	<ul style="list-style-type: none"> <li>Something specific about that setting is challenging (e.g., developmentally inappropriate expectations, bullying, difficult relationship with adult or another child(ren), separation anxiety)</li> <li>Symptoms are present but not observed or problematic in other settings</li> </ul>	<ul style="list-style-type: none"> <li>Recommend interventions to address specific challenge in that setting (e.g., school intervention, individual or parent-child therapy)</li> <li>Take further history to ensure the symptoms truly are not present in other settings, obtain VADRS from other caregivers</li> </ul>
<b>Symptoms started soon after major life change, trauma, or other stressors</b>	<ul style="list-style-type: none"> <li>PTSD</li> <li>Anxiety disorder</li> <li>Mood disorder (especially depression)</li> <li>Sleep disorder</li> </ul>	<ul style="list-style-type: none"> <li>Assess for safety</li> <li>Review signs of PTSD, anxiety, mood, sleep (consider PSC in children &gt; 6)</li> <li>Address stressor-related symptoms (relaxation strategies, consider referral for therapy)</li> </ul>
<b>Fewer than 6 symptoms</b>	<ul style="list-style-type: none"> <li>Other disorder including developmental delay, anxiety, mood, sleep, (consider PSC in children &gt; 6)</li> </ul>	<ul style="list-style-type: none"> <li>Address non-ADHD symptoms as indicated</li> <li>Monitor closely using VADRS or PSC and history</li> </ul>
<b>Parent Vanderbilt negative, teacher positive</b>	<ul style="list-style-type: none"> <li>Different behaviors in home and school (see 1 setting above)</li> <li>Developmental delay or learning problems</li> <li>Separation anxiety disorder</li> <li>Parent accommodation to child's behavior patterns (sees as normal)</li> <li>High teacher stress or developmentally inappropriate expectations</li> </ul>	<ul style="list-style-type: none"> <li>Confirm parent observations with parent to confirm validity of VADRS</li> <li>Address any concern identified</li> </ul>
<b>Teacher Vanderbilt negative, parent Vanderbilt positive</b>	<ul style="list-style-type: none"> <li>Teacher VADRS nearly positive</li> <li>Child's behavior is more organized structured setting in school</li> <li>Child is inhibited and anxious in school</li> <li>Different behavior at home and school</li> <li>Teacher does not know child well</li> <li>High parental stress or developmentally inappropriate expectations</li> </ul>	<ul style="list-style-type: none"> <li>Confirm parent observations with parent to confirm validity of VADRS</li> <li>Address any concern identified</li> </ul>

VADRS= Vanderbilt ADHD Rating Scale PSC= Pediatric Symptom Checklist

## Helpful tools in assessment

PHQ-9 — Nine Symptom Checklist

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things			
2. Feeling down, depressed, or hopeless			
3. Trouble falling asleep, staying asleep, or sleeping too much			
4. Feeling tired or having little energy			
5. Poor appetite or overeating			
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down			
7. Trouble concentrating on things such as reading the newspaper or watching television			
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual			
9. Thinking that you would be better off dead or that you would hurt yourself or someone else			

Not Difficult at All    Somewhat Difficult    Very Difficult    Extremely Difficult

Being a parent is not easy, so we are checking in with everyone about some common challenges. If you have more than one child being seen today, please answer "yes" if it applies to any one of them. This is voluntary. You don't have to answer any question you prefer not to. Thanks for helping us take the best possible care of your child!

PLEASE CHECK:

1. Yes/No: Do you need the phone number for Poison Control?

2. Yes/No: Does anyone smoke tobacco in home?

3. Yes/No: In the last year, did you worry that your food would run out before you get money or Food Stamps to buy more?

4. Yes/No: In the last year, did the food you bought just not last and you didn't have money to get more?

5. Yes/No: Do you often feel your child is difficult to take care of?

6. Yes/No: Do you sometimes find you need to hit/spank your child?

7. Yes/No: Do you wish you had more help with your child?

8. Yes/No: Do you often feel under extreme stress?

9. Yes/No: In the past month, have you often felt down, depressed, or hopeless?

10. Yes/No: In the past month, have you felt very little interest or pleasure in things you used to enjoy?

11. Yes/No: In the past year, have you been afraid of your partner?

12. Yes/No: In the past year, have you had a problem with drugs or alcohol?

13. Yes/No: In the past year, have you felt the need to cut back on drinking or drug use?

Has your child ever:

14. Yes/No: Been in a car accident?

15. Yes/No: Been spanked from you for prolonged time?

16. Yes/No: Seen/heard someone else get hurt (in or outside the home)?

17. Yes/No: Experienced major medical event or procedure (like surgery)?

18. Yes/No: Experienced major loss of someone or procedure (through death, moving away, incarceration)?

19. Yes/No: Lived through a major natural disaster?

20. Yes/No: Lived through a major family emergency (like a house fire, medical crisis, etc.)?

21. Yes/No: Had other major frightening events happen? Please tell us what happened: \_\_\_\_\_

Brief Early Childhood Screening Assessment

Feelings and behavior are important parts of health and wellness. Please complete the questions below, so your child's pediatric provider can take the best possible care of your child.

Child name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your name: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle the number that best describes your child compared to other children the same age. The last 4 items are about you as a parent.

AND, please circle the "X" if you are concerned and would like help with the item (please circle a number as well).

Item	Never	Sometimes	Often	Very Often
1. Seems sad, cries a lot				
2. Is difficult to comfort when hurt or distressed				
3. Avoids being touched				
4. Avoids situations that remind of scary events				
5. Talks others on purpose (sings, teases, looks)				
6. Doesn't seem to listen to adults talking to her/him				
7. Battles over food and eating				
8. In the past month, have you felt very little interest or pleasure in things you used to enjoy?				
9. Argues with adults				
10. Breaks things during tantrums				
11. Is easily startled or scared				
12. Has trouble interacting with other children				
13. Fidgets, can't sit quietly				
14. In groups, seems to separate from parent				
15. Seems nervous or scared a lot				
16. Shows other people for mistakes				
17. Has a hard time getting attention to tasks or activities				
18. Is always "on the go"				
19. Has trouble with small things				
20. Has trouble with small things				
21. Is very obedient				
22. Has unusual repetitive behaviors (rocking, flapping)				
23. Doesn't seem to know what fun is				
24. I feel less stressed to enjoy my child				
25. I get more frustrated than I want to with my child's behavior				

Are you concerned about your child's emotional or behavioral development? Yes/No

Any comments you want to share: \_\_\_\_\_

Pediatric Symptom Checklist-17 (PSC-17)

Complete this form for \_\_\_\_\_ Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Please mark under the heading that best fits your child.

Item	NEVER	SOMETIMES	OFTEN
1. Fidgety, unable to sit still			
2. Talks back, defiant			
3. Disrupts too much			
4. Refuses to share			
5. Does not understand other people's feelings			
6. Feels hopeless			
7. Has trouble concentrating			
8. Fights with other children			
9. Is down on him or herself			
10. Blames others for his or her troubles			
11. Seems to be having less fun			
12. Does not listen to rules			
13. Acts as if he/she is a monster			
14. Teases others			
15. Worries a lot			
16. Takes things that do not belong to him or her			
17. Distracted easily			

Scoring: Fill in shaded box on right with "Never", "Sometimes", or "Often". Sum the columns. PSC-17 Attention Score is sum of columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17. PSC-17 Total Score is sum of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17.

Screen for Child Anxiety & Related Disorders (SCARED)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Read each item carefully and circle the "Yes" or "No" that best describes you. The first 10 items are for children 8 years of age and older. The last 10 items are for children 6-7 years of age.

Item	Yes	No
1. When I feel frightened, it is hard to breathe		
2. I get headaches when I am at school		
3. I am like the other people I can't have fun		
4. I get scared if I sleep away from home		
5. I worry about other people being angry		
6. When I get frightened, I feel like my stomach is sick		
7. I am nervous		
8. I follow my mother or father when they go		
9. People tell me that I am nervous		
10. I feel nervous with people I don't know well		
11. I get uncomfortable at school		
12. When I get frightened, I feel like I am going crazy		
13. I worry about sleeping alone		
14. I worry about being a good student		
15. When I get frightened, I feel like my legs are not real		
16. I have nightmares about something bad happening to my family		
17. I worry about going to school		
18. When I get frightened, my heart beats fast		
19. I get shaky		
20. I have nightmares about something bad happening to me		

### Vanderbilt ADHD Rating SCALE

ADHD measure used for screening and monitoring treatment effects. Validated in children 6-12 but often used across children/adolescents

### Safe Environment for Every Kid (SEEK)

Examines risks in the home environment. Can be used across all ages. TECC handbook offers resources to address identified needs

### Brief Early Childhood Screening Assessment (B-ECSA)

Validated measure of child mental health problems for children 1 1/2-5yo. Not diagnosis-specific. Can be used to monitor progress

### Pediatric Symptom Checklist-17 (PSC-17)

Validated measure of child mental health problem for children 6-18. Using scale scores offers additional information about diagnostic categories.

### Screen for Child Anxiety & Related Disorders (SCARED)

Measure of child anxiety with child and parent report forms. Validated in children over 8, but can be used with caution in younger children.

All measures available in English, Spanish. Most also available in other languages