Fax to Dr. Bimbela: 888-958-5269

Educator Feedback

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Sometimes	Very Often
1. Can't sit still, restless, or **hyperactive**.	0	1	2
2. Difficulty keeping **attention** to what needs to be done.	0	1	3
3. Does not seem to **listen** when spoken to directly.	0	1	2
4. **Defiant** and talks back to staff.	0	1	2
5. Difficulty **organizing** tasks and activities.	0	1	2
6. **Explosive** and unpredictable behavior.	0	1	2
7. **Loses things**	0	1	2
8. Easily **distracted** by noises or other stimuli	0	1	2
9. **Forgetful** in daily activities	0	1	2
10. **Fidgets** with hands or feet or squirms in seat	0	1	2
11. **Leaves seat** when remaining seated is expected	0	1	2
12. **Runs about or climbs** too much when remaining seated is expected	0	1	2
13. Has difficulty playing or beginning quiet play activities	0	1	2
14. Is "**on the go**" or often acts as if "driven by a motor"	0	1	2
15. **Talks** too much	0	1	2
16. **Blurts out answers** before questions have been completed	0	1	2
17. Difficulty **waiting** his or her turn	0	1	2
18. **Sleeps** in class.	0	1	2
19. Does not follow **directions**.	0	1	2
20. **Breaks school** rules.	0	1	2
21. Gets into **fights**.	0	1	2
22. Disrupts class.	0	1	2
23. Appears **sad**.	0	1	2
24. Appears **angry**.	0	1	2
25. Appears **depressed**.	0	1	2
26. Appears **anxious**.	0	1	2

Notes: