Patient Self-Evaluation for ATTENTION DEFICIT/HYPERACTIVITY DISORDER

STUDENT'S PRIMARY CONCERN (Please state your primary concern)

WHAT LED YOU TO SEEK AN EVALUATION NOW?

PRESENTING PROBLEM
Rate the following activities 1-10 (1 meaning no difficulty staying focused to 10 being major difficulty):

- Paying attention in class ____
- Writing papers ____
- Studying for exams ____
- Talking with peers ____
- Working a job ____
- Other leisure activities ____

Rate the level of procrastination 1-10 (completing work ahead of time to 10 frequently staying up all night to complete tasks for the next day)

- Paying attention in class ____
- Writing papers ____
- Studying for exams ____
- Talking with peers ____
- Working a job ____
- Other leisure activities ____

Is test anxiety a problem? □ Yes □ No

If you are currently taking a stimulant medication or would like to be on a stimulant medication, are you taking it (or would you mostly be taking it) to:

□ Be able to stay awake to study when you get behind because of procrastination
□ Because of pressure/expectations from teachers and parents to perform better
□ To help with focus

PRESENT FUNCTIONING
GPA_______ Major______________________________________________________________
Have you been on academic probation? (circle) Currently □ Yes □ No
Previously □ Yes □ No
Never □ Yes □ No

Are you in danger of losing a scholarship? □ Yes □ No

Do your parents know about the problem? □ Yes □ No

Are your parents paying all or part of your tuition? □ Yes □ No

Do your parents feel OK about your school performance? □ Yes □ No

How much do you sleep? □ < 7hrs/night □ 7-8hrs/night □ > 8hrs/night

Do you have problems with your sleep?

□ Trouble falling asleep □ Snoring or sleep apnea □ Excessive daytime sleepiness
□ Trouble staying asleep □ Abnormal sleep schedule

Do you currently receive services? □ DRS □ Medical Provider □ Counselor
AGE OF ONSET

☐ 0-7 years
☐ 8-12 years
☐ 13-15 years
☐ 16-21 years
☐ 22-present

PRIOR ADHD HISTORY: Have you previously been seen for this? ☐ Yes ☐ No
If yes: When? ________________________________
Where? ____________________________________________
Were you tested? ____________________________________
Were you treated, and if so, with what? ________________________________

SCHOOL PERFORMANCE from PRE-SCHOOL to PRESENT: Describe any trouble starting school, did you ever repeat a grade, were you ever in any special classes, how would you describe your grades, did your teachers think that you did as well as you could, were you ever expelled or suspended from school, were you ever in physical fights.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

LIFE FEATURES: Describe any problems you had with the law; troubles with driving and frequent driving accidents and tickets; problems with temper; frequent changing of jobs; bills not paid on time; interrupting conversations; problems in areas other than just academic concerns.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
# RATING SCALES

## INATTENTION

### WHEN I WAS YOUNG

1. Often failed to give attention to careless mistakes.  
   - Yes  
   - No

2. Often had difficulty sustaining attention in tasks/play (easily distracted).  
   - Yes  
   - No

3. Often did not seem to listen when spoken to.  
   - Yes  
   - No

4. Often did not follow through on instructions and failed to finish tasks.  
   - Yes  
   - No

5. Often had difficulty organizing tasks/activities (poor time management).  
   - Yes  
   - No

6. Often avoided tasks requiring sustained mental effort (e.g. homework).  
   - Yes  
   - No

7. Often lost things necessary for tasks (misplaced things).  
   - Yes  
   - No

8. Often distracted by extraneous stimuli (difficulty finishing tasks).  
   - Yes  
   - No

   - Yes  
   - No

### CURRENTLY

1. Often fail to give attention to careless mistakes.  
   - Yes  
   - No

2. Often have difficulty sustaining attention in tasks/play (easily distracted).  
   - Yes  
   - No

3. Often do not seem to listen when spoken to.  
   - Yes  
   - No

4. Often do not follow through on instructions and fail to finish tasks.  
   - Yes  
   - No

5. Often have difficulty organizing tasks/activities (poor time management).  
   - Yes  
   - No

6. Often avoid tasks requiring sustained mental effort (e.g. homework).  
   - Yes  
   - No

7. Often lose things necessary for tasks (misplaces things).  
   - Yes  
   - No

8. Often distracted by extraneous stimuli (difficulty finishing tasks).  
   - Yes  
   - No

   - Yes  
   - No

## HYPERACTIVITY & IMPULSIVITY

### WHEN I WAS YOUNG

1. Often fidgeted with hands or feet or squirmed (shows inner restlessness).  
   - Yes  
   - No

2. Often left seat in classroom or meal table.  
   - Yes  
   - No

3. Often ran about or climbed excessively in inappropriate situations (felt overwhelmed).  
   - Yes  
   - No

4. Often had difficulty playing quietly (self-selected active jobs).  
   - Yes  
   - No

5. Often "on the go" driven by a motor (worked long hours or two jobs).  
   - Yes  
   - No

6. Often talked excessively.  
   - Yes  
   - No

7. Often blurted out answer before question completed (made impulsive job changes).  
   - Yes  
   - No

8. Often had difficulty waiting turn (drove too fast, had traffic accidents).  
   - Yes  
   - No

9. Often interrupted or intruded on others (showed irritability or quickness to anger).  
   - Yes  
   - No

### CURRENTLY

1. Often fidget with hands or feet or squirms (shows inner restlessness).  
   - Yes  
   - No

2. Often leave seat in classroom or meal table.  
   - Yes  
   - No

3. Often run about or climb excessively in inappropriate situations (feels overwhelmed).  
   - Yes  
   - No

4. Often have difficulty playing quietly (self-select active jobs).  
   - Yes  
   - No

5. Often "on the go" driven by a motor (work long hours or two jobs).  
   - Yes  
   - No

6. Often talk excessively.  
   - Yes  
   - No

7. Often blurt out answer before question completed (make impulsive job changes).  
   - Yes  
   - No

8. Often have difficulty waiting turn (drive too fast, have traffic accidents).  
   - Yes  
   - No

9. Often interrupt or intrude on others (show irritability or quickness to anger).  
   - Yes  
   - No
Have you noticed the above symptoms in your academic life?  ☐ Yes  ☐ No  Give examples:____________________

Have you noticed the above symptoms in your work and/or social - daily life?  ☐ Yes  ☐ No  Give examples:____

MOOD ASSESSMENT
On a scale of 1-10 with 10 representing major difficulties, rate any problems you have with:
   Depression ___
   Anxiety ___
   Sleep ___
   Eating ___
   Anger ___
   Fatigue ___
   Sexual ___

PAST PSYCHIATRIC HISTORY
Ever seen a counselor or psychiatrist before?  ☐ Yes  ☐ No  If yes, give details:____________________________________

Have you been hospitalized for a psychiatric problem?  ☐ Yes  ☐ No  If yes, give details:______________________________

Have you ever had problems with depression?  ☐ Yes  ☐ No  If yes, give details:____________________________________

Have you ever had problems with anxiety?  ☐ Yes  ☐ No  If yes, give details:____________________________________

Have you ever had problems with bipolar disorder?  ☐ Yes  ☐ No  If yes, give details:_____________________________

Have you ever had problems with a learning disorder?  ☐ Yes  ☐ No  If yes, give details:_____________________________

REVIEW OF SYSTEMS: Any current medical concerns?  ☐ Yes  ☐ No  If yes, describe:______________________________

   Skin  ☐ Yes  ☐ No
   Vision and hearing  ☐ Yes  ☐ No
   Constant runny nose or stuffy nose  ☐ Yes  ☐ No
   Shortness of breath or chest pain  ☐ Yes  ☐ No
   Feel like your heart is beating irregularly  ☐ Yes  ☐ No
   Nausea, vomiting or diarrhea  ☐ Yes  ☐ No
   Hurting or burning when urinate  ☐ Yes  ☐ No
   Muscle pains or joints red/swollen  ☐ Yes  ☐ No
   Frequent headaches  ☐ Yes  ☐ No
   Head injuries where you have lost consciousness  ☐ Yes  ☐ No
Brain infections  □ Yes  □ No
Tics or unusual body movements (Tourette’s)  □ Yes  □ No
If female, are you sexually active?  □ Yes  □ No
If female, are you on any form of birth control?  □ Yes  □ No  If yes, what kind?

DEVELOPMENTAL HISTORY
Any problems with the pregnancy, labor and delivery?  □ Yes  □ No  If yes, give details:

Did you walk and talk on time?  □ Yes  □ No  If no, give details:

Did you have normal relationships with peers?  □ Yes  □ No  If no, give details:

MEDICATIONS
Do you take any medications?  □ Yes  □ No  If yes, describe:

Do you take any over-the-counter medications, herbs or supplements?  □ Yes  □ No  If yes, describe:

ALLERGIES
Are you allergic to any medications?  □ Yes  □ No  If yes, describe:
Any other allergies  □ Yes  □ No  If yes, describe:

PAST MEDICAL HISTORY
Hospitalized over night?  □ Yes  □ No  If yes, describe:

Surgeries  □ Yes  □ No  If yes, describe:

Illnesses or accidents in the past of specific concern?  □ Yes  □ No  If yes, describe:

SOCIAL HISTORY
Tobacco use  □ Yes  □ No  If yes, describe as below.
□ Never smoked □ Less than ½ ppd
□ Quit for more than a year □ 1 ppd
□ Quit for less than a year □ > 1 ppd
Drinks  □ Yes  □ No  If yes, approximately _____ alcoholic drinks per week on the average.
CAGE score:
Drunk how many times per week?  _______
Number of blackouts ever total  _______
Recreational Drug use  _______
Pot, marijuana, hashish  □ Yes  □ No  Current_____ Past_____ Frequency_____
Amphetamines, stimulants, uppers, speed  □ Yes  □ No  Current_____ Past_____ Frequency_____
Barbituates, sedatives, downers, sleeping pills  □ Yes  □ No  Current_____  Past_____  Frequency_____
Cocaine, crack, coke  □ Yes  □ No  Current_____  Past_____  Frequency_____
Heroin, other opiates  □ Yes  □ No  Current_____  Past_____  Frequency_____
Psychedelics, LSD, other  □ Yes  □ No  Current_____  Past_____  Frequency_____

Other:
Prescription Drug misuse  □ Yes  □ No  Describe:__________________________________________

Caffeine usage: More than 2 servings a day?  □ Yes  □ No

Relationship Issues/concerns  □ Yes  □ No  Longest relationship?______________________________
Problems in work situation  □ Yes  □ No  Longest held job?______________________________
Do you have specific thoughts about what you want to do with your life?  □ Yes  □ No  Describe:___________

FAMILY HISTORY

Any biologic relatives with depression?  □ Yes  □ No  If yes, give details:____

Any biologic relatives with anxiety?  □ Yes  □ No  If yes, give details:____

Any biologic relatives with bipolar disorder (manic depressive disorder)?  □ Yes  □ No  If yes, details:____

Any biologic relatives with substance abuse disorder?  □ Yes  □ No  If yes, details:____

Any biologic relatives with Attention Deficit/Hyperactivity Disorder?  □ Yes  □ No  If yes, details:____

Any biologic relatives with a Learning Disorder?  □ Yes  □ No  If yes, details:____

Any biologic relatives with Tourettes Syndrome or Tic Disorder?  □ Yes  □ No  If yes, details:____

Any biologic relatives with thyroid disorder?  □ Yes  □ No  If yes, give details:____

Any biologic relatives with diabetes?  □ Yes  □ No  If yes, give details:____

Any biologic relatives with early heart disease, high blood pressure or stroke?  □ Yes  □ No  If yes, details:____

Any biologic relatives with cancer?  □ Yes  □ No  If yes, give details:____

Any other medical illnesses that run in the family?  □ Yes  □ No  If yes, give details:____