

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?

AGE OF ONSET

- 0-7 years
- 8-12years
- 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
9. Often forgetful. 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
9. Often forgetful. 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
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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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vision and hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Constant runny nose or stuffy nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath or chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Feel like your heart is beating irregularly | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea, vomiting or diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hurting or burning when urinate | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle pains or joints red/swollen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Head injuries where have lost consciousness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brain infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tics or unusual body movements(Tourettes) | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: _____

ALLERIES

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 1/2 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, give details: _____

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

Any biologic relatives with a Learning Disorder? Yes No If yes, give details: _____

Any biologic relatives with Tourettes Syndrome or Tic Disorder? Yes No If yes, give 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, give 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: _____
