

Student ADHD Questionnaire

Date:			
Student Name:		Student Birthdate:	
Name/location of high school you attended:		Yr of graduation:	GPA:
How many years have you attended UF?		What is your current GPA?	
Current academic standing: <input type="checkbox"/> FR <input type="checkbox"/> SO <input type="checkbox"/> JR <input type="checkbox"/> SR <input type="checkbox"/> Graduate student: degree program :			
What is your current major?		How many times have you changed majors?	
Where at UF where do you live? <input type="checkbox"/> dorm <input type="checkbox"/> sorority/fraternity house <input type="checkbox"/> on campus house <input type="checkbox"/> off campus housing <input type="checkbox"/> other (describe):			
Reason for this Evaluation - Please list the symptoms and impairments that led you to seek an ADHD evaluation. If you have been diagnosed with ADHD in the past, list your current most impairing symptoms off medication. Please include details of your concerns and those expressed by others (professors, roommates, parents and other significant adults in your life) (May continue on back of paper if more space needed.)			
Have you ever been diagnosed with ADHD? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how old were you?			
Which type? <input type="checkbox"/> ADHD, inattentive predominant type <input type="checkbox"/> ADHD, combined type <input type="checkbox"/> ADHD, hyperactive-impulsive predominant type			
Who made the diagnosis? <input type="checkbox"/> Psychologist <input type="checkbox"/> Pediatrician <input type="checkbox"/> Family MD <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other:			
Which of the following were involved in making the diagnosis of ADHD? <input type="checkbox"/> Clinical interview and observation <input type="checkbox"/> Checklists by you <input type="checkbox"/> Checklists by parents <input type="checkbox"/> Checklists by teachers <input type="checkbox"/> Psycho-educational testing <input type="checkbox"/> Computerized testing <input type="checkbox"/> other (specify):			
Have you ever been diagnosed with a learning disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Please check the following items that were true for you most or all of the time during each period:			
	ELEMENTARY SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL
Blurted out answers before the questions have been completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not sustain attention to schoolwork during classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talked excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble playing or doing leisure things quietly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acted or spoke without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fidgeted or got out of seat excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not give close attention to details, made careless mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Required disciplinary interventions, e.g. sat in front of the class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble organizing activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had problems with peers (eg difficulty waiting for turn)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently lost things for tasks or activities (eg. books, assignments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did not appear to be listening when spoken to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failed to finish schoolwork and chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did just enough to get by	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe details/examples of checked items in ELEMENTARY SCHOOL:			

Describe details/examples of checked items in MIDDLE SCHOOL:
Describe details/examples of checked items in HIGH SCHOOL:
Medical History:
Current medical illness(es), if any:
Current medications, if any:
History of thyroid disease? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure
History of head injury with loss of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure
Current sleep disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure
<ul style="list-style-type: none"> • Trouble falling asleep? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure • Difficulty staying asleep? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure • Disrupted breathing or loud snoring during sleep? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure • Dozing off during the day? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure • Average amount of time before falling asleep min • Average # of hours of sleep per night hrs
History of heart disease (palpitations, murmurs, congenital heart disease)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure, If yes, please describe:
<ul style="list-style-type: none"> • Have you ever fainted? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure, If yes, please describe circumstances: • Any family history of heart disease? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure, If yes, please describe: • Have any family member died from heart disease before the age of 50? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure, If yes, please describe:
Any family history of ADHD? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure, If yes, please describe:
Any family history of learning disabilities? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure, If yes, please describe:
History of alcohol and drug use: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.)
Driving/Legal History
How many motor vehicle accidents have you been involved with as a driver?
In how many of these were you "at fault"?
How many of these resulted from being distracted?
How many traffic tickets (not including parking tickets) have you received?
How many parking tickets?
Has your driver's license ever been suspended? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure # DUI/DWI citations:
Have you had any legal problems other than the above? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure
If yes, please describe and give date/age:

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

In the past 6 months..... Please provide examples/details in the space below if indicating "Sometimes" "Often" or "Very Often"	Never	Rarely	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often do you have difficulty getting things in order when you have to do a task that requires organization? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How often do you have problems remembering appointments or obligations? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often do you feel overly active and compelled to do things, like you were driven by a motor? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often do you make careless mistakes when you have to work on a boring or difficult project? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How often do you misplace or have difficulty finding things at home or at work? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. How often are you distracted by activity or noise around you? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. How often do you feel restless or fidgety? Examples/details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
15. How often do you find yourself talking too much when you are in social situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
18. How often do you interrupt others when they are busy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examples/details:					
Is there any additional information that is relevant to the above situations? If so, please describe:					

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Please list the medications you are currently taking or have taken most recently for ADHD:				
Name of medication/maximum dose	How long & age(s) while taking?	Was it effective?	What side effects, if any?	Why did you stop taking this?

Other past psychiatric history:	
Have you ever been diagnosed with any of the following mental health conditions?	
• Depression <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:	
• Anxiety disorder <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:	
• Bipolar disorder <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:	
• Other (specify) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not sure details:	

Which emotional / behavioral health medications (like antidepressants, mood stabilizers) have been prescribed for you?				
Name of medication/maximum dose	How long & age(s) while taking?	Was it effective?	What side effects, if any?	Why did you stop taking this?