Adult Self-Report Scale (ASRS) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often	Score
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	0	1	2	3	4	
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	0	1	2	3	4	
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	1	2	3	4	
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2	3	4	
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	0	1	2	3	4	
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	1	2	3	4	
7. How often do you misplace or have difficulty finding things at home or at work?	0	1	2	3	4	
8. How often are you distracted by activity or noise around you?	0	1	2	3	4	
9. How often do you have problems remembering appointments or obligations?	0	1	2	3	4	
					Part A – Total	
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3	4	
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	4	
12. How often do you feel restless or fidgety?	0	1	2	3	4	
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	4	
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3	4	
15. How often do you find yourself talking too much when you are in social situations?	0	1	2	3	4	
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?	0	1	2	3	4	
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	0	1	2	3	4	
18. How often do you interrupt others when they are busy?	0	1	2	3	4	
					Part B – Total	

NAME _____ **DATE** _____ **(MRN** _____**)**

Adult ADHD/ADD Questionnaire – Everett Clinic Behavioral Health

YES / NO / UNSURE: Any form or letter for school or work that you want completed today?
YES / NO / UNSURE: Do you have old school report cards, transcripts, test reports, work samples/reviews, or other documents that describe your past functioning?
YES / NO / UNSURE: Anybody we can call or talk to who knows firsthand how AHDD/ADD issues have affected you?

YES / NO / UNSURE: Willing to learn new organizational and self-management strategies
YES / NO / UNSURE: Interested in ADHD information from websites, handouts, or books
YES / NO / UNSURE: Want to try medication

History of ADHD Symptoms

YES / NO / UNSURE: Were you a difficult, colicky baby or toddler?
YES / NO / UNSURE: As a preschooler, did parents or other people describe you as hyper or always on the go?
YES / NO / UNSURE: Did you have acting out or behavior problems in school?
YES / NO / UNSURE: Learning disabilities in reading, writing, math, or speech, or special education program/ IEP in school

Have you had ADHD/ADD issues in:
YES / NO / UNSURE: Elementary school
YES / NO / UNSURE: Middle school
YES / NO / UNSURE: High school
YES / NO / UNSURE: College or training program
YES / NO / UNSURE: Jobs, or difficulty keeping a job
YES / NO / UNSURE: Friendships or social activities
YES / NO / UNSURE: Intimate relationships/partnerships
YES / NO / UNSURE: Handling things at home
YES / NO / UNSURE: Managing finances

YES / NO / UNSURE: Coffee, caffeine, or power drinks help me focus and perform
YES / NO / UNSURE: Have tried ADHD medication and it helped
YES / NO / UNSURE: Previously diagnosed with ADHD/ADD
YES / NO / UNSURE: Any close biological relative (parent, sibling, child) with diagnosed ADHD/ADD or highly likely
YES / NO / UNSURE: ADHD medication has helped a close biological relative

Other Conditions Now or Past

YES / NO / UNSURE: Medical conditions
YES / NO / UNSURE: Medications
YES / NO / UNSURE: Vision or hearing problems
YES / NO / UNSURE: Concussions or head injuries (for example, with vision disturbance, disorientation, or nausea)
YES / NO / UNSURE: Cardiovascular issues (high blood pressure or heart abnormalities)
YES / NO / UNSURE: Glaucoma
YES / NO / UNSURE: Hyperthyroidism
YES / NO / UNSURE: Seizure history
YES / NO / UNSURE: Tics (repetitive, unwanted muscle movements or verbal twitches) or family history of Tourette's Syndrome
YES / NO / UNSURE: Substances or alcohol problems, now or past, or marijuana use
YES / NO / UNSURE: More than a year since you had a medical checkup and basic metabolic labs (blood and urine tests)

YES / NO / UNSURE: Childhood problems (physical abuse, family fighting, unwanted sexual touching or abuse, neglect, losses, PTSD)
YES / NO / UNSURE: Anxiety, worrying, or panic
YES / NO / UNSURE: Depression or mood swings
YES / NO / UNSURE: Sleep problems (lack of sleep, tiredness, nightmares, snoring, or sleep apnea)
YES / NO / UNSURE: Eating problems or disorders, poor eating habits
YES / NO / UNSURE: Any close biological relative with major mental health issues like major depression, bipolar, or schizophrenia