ADHD Assessment – Patient Self-Report v1

For the patient to complete themselves

Once completed, the patient should send both this form, and a completed Supporting Evidence form to their GP who will then complete the referral to the ADHD service.

We understand that the length of the form can be challenging, but the information is necessary for providing this service. Please fill out this form as much as you can.

Patient's Details		
Contact Email		
Title		
Forename		
Surname		
Preferred Name		
Date of birth		
Gender		
Assigned sex at birth	○ Male ○ Female ○ Prefer not to state	
Address & Postcode		
Ethnicity		
1st language		
Do you need an interpreter?	○ Yes ○ No	Language

Patient phone numbers		Preferred Number	Can leave messages
Home		Yes ☐	Yes ☐
Work		Yes ☐	Yes ☐
Mobile		Yes ☐	Yes ☐

Additional contact details (Optional) Significant friends/relatives who the patient agrees may be contacted if the patient cannot be contacted.			
Name		Phone	
Name		Phone	
Name		Phone	

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

This form should be completed by the patient.

If there are 4 or more marks in shaded boxes in Part A then ADHD is possible, so your GP will normally refer you.

Please tick the box next to each item below that best describes your behaviour **during the past six months.** **Date completed: _____**		**Never (0)**	**Rarely (1)**	**Some-times (2)**	**Often (3)**	**Very Often (4)**
Part A						
1	How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2	How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3	How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5	How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6	How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐
Part B						
7	How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10	How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11	How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13	How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14	How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15	How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐

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?	☐	☐	☐	☐	☐
17	How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
18	How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐

BAARS-IV Self-Report (Current Symptoms)
This form should be completed by the patient.

How often do you experience these 27 symptoms? Please tick the box next to each item below that best describes your behaviour **during the past six months.** **Date completed: _____**		**Never/ Rarely (1)**	**Some -times (2)**	**Often (3)**	**Very Often (4)**
Section 1 (Inattention)					
1	Fail to give close attention to details or make careless mistakes in my work or other activities	☐	☐	☐	☐
2	Difficulty sustaining my attention in tasks or fun activities	☐	☐	☐	☐
3	Don't listen when spoken to directly	☐	☐	☐	☐
4	Don't follow through on instructions and fail to finish work or chores	☐	☐	☐	☐
5	Have difficulty organizing tasks and activities	☐	☐	☐	☐
6	Avoid, dislike, or am reluctant to engage in tasks that require sustained mental effort	☐	☐	☐	☐
7	Lose things necessary for tasks or activities	☐	☐	☐	☐
8	Easily distracted by extraneous stimuli or irrelevant thoughts	☐	☐	☐	☐
9	Forgetful in daily activities	☐	☐	☐	☐
Section 2 (Hyperactivity)					
10	Fidget with hands or feet or squirm in seat	☐	☐	☐	☐
11	Leave my seat in classrooms or in other situations in which remaining seated is expected	☐	☐	☐	☐
12	Shift around excessively or feel restless or hemmed in	☐	☐	☐	☐
13	Have difficulty engaging in leisure activities quietly (feel uncomfortable, or am loud or noisy)	☐	☐	☐	☐
14	Feel "on the go" or act as if "driven by a motor" (or feel like I have to be busy or always doing something)	☐	☐	☐	☐
Section 3 (Impulsivity)					
15	Talk excessively (in social situations)	☐	☐	☐	☐
16	Blurt out answers before questions have been completed, completed others' sentences, or jump the gun	☐	☐	☐	☐

17	Have difficulty awaiting my turn	☐	☐	☐	☐
18	Interrupt or intrude on others (butt into conversations or activities without permission or take over what others are doing).	☐	☐	☐	☐
Section 4 (Sluggish Cognitive Tempo)					
19	Prone to daydreaming when I should be concentrating on something or working	☐	☐	☐	☐
20	Have trouble staying alert or awake in boring situations	☐	☐	☐	☐
21	Easily confused	☐	☐	☐	☐
22	Easily bored	☐	☐	☐	☐
23	Spacey or “in a fog”	☐	☐	☐	☐
24	Lethargic, more tired than others	☐	☐	☐	☐
25	Underactive or have less energy than others	☐	☐	☐	☐
26	Slow moving	☐	☐	☐	☐
27	I don’t seem to process information as quickly or as accurately as others	☐	☐	☐	☐

	Section 5 (Summary) Please answer these three questions as prompted.
28	Did you experience **any** of these 27 symptoms at least “Often” or “Very Often”? (Did you tick an “Often” or “Very Often” above?) ○ Yes ○ No
29	If so, how old were you when these symptoms began? I was _____ years old.
30	If so, in which of these settings did those symptoms impair your functioning? Please tick the box next to all of the areas that apply to you. ☐ School ☐ Home ☐ Work ☐ Social Relationships

BAARS-IV Self-Report (Childhood Symptoms) This form should be completed by the patient.					
Please tick the box next to each item below that best describes your behaviour **when you were a child between 5 and 12 years of age.** **Date Completed: _____**		**Never/ Rarely (1)**	**Some -times (2)**	**Often (3)**	**Very Often (4)**
Section 1 (Inattention)					
1	Failed to give close attention to details or made careless mistakes in my work or other activities	☐	☐	☐	☐
2	Had difficulty sustaining my attention in tasks or fun activities	☐	☐	☐	☐
3	Didn't listen when spoken to directly	☐	☐	☐	☐
4	Didn't follow through on instructions and failed to finish work or chores	☐	☐	☐	☐
5	Had difficulty organizing tasks and activities	☐	☐	☐	☐
6	Avoided, disliked, or was reluctant to engage in tasks that require sustained mental effort	☐	☐	☐	☐
7	Lost things necessary for tasks or activities	☐	☐	☐	☐
8	Was easily distracted by extraneous stimuli or irrelevant thoughts	☐	☐	☐	☐
9	Was forgetful in daily activities	☐	☐	☐	☐
Section 2 (Hyperactivity-Impulsivity)					
10	Fidgeted with my hands or feet or squirmed in my seat	☐	☐	☐	☐
11	Left my seat in classrooms or in other situations in which remaining seated was expected	☐	☐	☐	☐
12	Shifted around excessively or felt restless or hemmed in	☐	☐	☐	☐
13	Had difficulty engaging in leisure activities quietly (felt uncomfortable, or was loud or noisy)	☐	☐	☐	☐
14	Was "on the go" or acted as if "driven by a motor"	☐	☐	☐	☐
15	Talked excessively	☐	☐	☐	☐
16	Blurted out answers before questions had been completed, completed others' sentences, or jumped the gun	☐	☐	☐	☐
17	Had difficulty awaiting my turn	☐	☐	☐	☐
18	Interrupted or intruded on others (butted into conversations or activities without permission or took over what others were doing).	☐	☐	☐	☐

Section 3 (Summary) Please answer these two questions as prompted.	
19	Did you experience **any** of these 18 symptoms at least “Often” or “Very Often”? (Did you tick an “Often” or “Very Often” above?) ○ Yes ○ No
20	If so, in which of these settings did those symptoms impair your functioning? Please tick the box next to all of the areas that apply to you. ☐ School ☐ Home ☐ Social Relationships

Personal History

Personal history has a vital role in the Adult ADHD assessment. We believe it is important to engage and support our patients in writing their own history.

This section should be completed by the patient. Please fill this out as best you can, with help from your family or community as needed. There are no ‘wrong’ answers. It is your story.

Birth

Duration of pregnancy, complications, history of sickness, mother history of smoking, alcohol consumption, extended periods of stay in the hospital, breastfeeding, siblings. Any events you and/or your family consider to be relevant.

Early development

Comparison with siblings if applicable, period achieving milestones e.g., walking, talking. Any events you and/or your family consider to be relevant.

Primary school

Brief example of academic performance, comparison with peers, progress with writing, ability to make friendships, history of bullying if available, "getting in trouble events", injuries. Any events you and/or your family consider to be relevant.

Secondary school

Brief example of academic performance, comparison with peers, ability to make friendships, history of bullying if applicable, "getting in trouble events", injuries, history of alcohol/illicit substance use if applicable, personal relationships. Any events you and/or your family consider to be relevant.

GCSEs and A levels – if applicable

Brief description of the grades if attended. Expectations or difficulties. Comparison with peers.

Adult relationships and educational/employment history – if applicable

Brief history of your educational/employment history, children.

Current social circumstances and goals

Brief summary of your current social circumstances e.g., housing, employment, relationships, hobbies, goals.

Family background

Brief description of the family background (parents, siblings): education, employment, marital status, frequent history of re-location. Any events you and/or your family consider to be relevant.

Thank you for taking the time to complete this long and detailed form.

Please send the completed form AND the completed Supporting Evidence form back to your GP who will complete the referral and send both forms to the chosen service.

The Service will acknowledge receipt of the form to the GP and the patient and advise on what happens next.