Adult ADHD Symptom Screener

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| --- | --- | --- | --- | --- | --- |
| Name |  | CHI |  | 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, place an X in the box 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 |
| 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? |  |  |  |  |  |

ADHD Signs

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| --- | --- | --- | --- | --- | --- |
| Name |  | CHI |  | Date |  |
| Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page.  | Never | Rarely | Sometimes | Often | Very often |
| 1. How often do you have difficulty listening? |  |  |  |  |  |
| 2. Are you easily distracted? |  |  |  |  |  |
| 3. Do you feel restless or have an inability to sit still in low stimulation situations (ie a waiting room)? |  |  |  |  |  |
| 4. Do you have difficulty keeping quiet or talking out of turn? |  |  |  |  |  |
| 5. Do you often blurt out responses, or find it difficult when talking at the appropriate time in everyday conversations? |  |  |  |  |  |
| 6. Do you have trouble waiting if there is nothing to do? |  |  |  |  |  |
| 7. Do you often interrupt of intrude on others? |  |  |  |  |  |
| 8. Do you suffer from irritability, impatience or frustration? |  |  |  |  |  |

When you were younger (ie before the age of 12), did any of your symptoms have a significant impact on your abilities in the following situations:

Please circle

1. At School Yes / No
2. At Home Yes / No
3. Socially Yes / No

If yes, then please detail below

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We would also require a collateral history from your parents/family with regards to your behavior in childhood, this can take the form of an email to yourself, which you can forward to the practice (clinical.s70592@nhslothian.scot.nhs.uk)

