Name:______________________________________

Date of birth:________________________________

ADULT ADHD EVALUATION INTAKE FORM

Date of intake appointment:_________________ Referred by:__________________________

What current symptoms/issues are you having that caused you to come in today?

____
____
____

What areas of your life are most affected by your current symptoms?

____
____
____

When did you first notice these symptoms?

____
____
____

Who referred you for ADHD testing? ____

Has anyone else in your family been tested for or diagnosed with ADHD? If so, list the family member(s) and when they were tested or diagnosed.

____
____
____

Educational history

Highest level of education: ____
Diploma or GED? (year) _______GPA or average grades:_____________
Postsecondary education: ____
Degree(s) obtained: ____

Below is a list of common education problems. For each area, please circle the level(s) of education when you had the issue.
(Elementary School = grades K to 4; Middle School = grades 5 to 8; High School = grades 9 to 12; Postsecondary = any college, vocational or technical training after high school)

Academic problems

(circle all that apply; if none, skip to the next issue)
Elementary Middle School High School Postsecondary

In which classes/subjects did you have the most trouble?____

In which classes did you excel?____

More information:

Name:_______________________________________

Date of birth:________________________________

Tutoring/special education
(circle all that apply; if none, skip to the next issue)
Elementary Middle School High School Postsecondary

If you had special education services, what was your reported area of disability?______________________________

If you were tutored, which subjects did you need extra help with?____

More information:

Behavior/discipline problems
(circle all that apply; if none, skip to the next issue)
Elementary Middle School High School Postsecondary

Were you ever suspended or expelled from school?_________________

Did you ever get into any physical or verbal fights at school?_________

Did you often get in trouble for being disruptive at school?___________

More information:

Disorganization (messy desk or locker, unable to organize projects)
(circle all that apply; if none, skip to the next issue)
Elementary Middle School High School Postsecondary

More information:

Social/peer issues
(circle all that apply; if none, skip to the next issue)
Elementary Middle School High School Postsecondary

Did you have trouble making or keeping friends?__________________

Did you often have conflict with others?__________________________

Were you often teased or bullied by others?______________________

Were you shy or withdrawn as a child?___________________________

More information:

Name:______________________________________

Date of birth:________________________________

Class attendance problems
(circle all that apply; if none, skip to the next issue)
Elementary Middle School High School Postsecondary

Were you often late for school or for class?_______________________

Did you often miss several days of school (not for illness)? __________

More information:

Procrastination/poor time management
(circle all that apply; if none, skip to the next issue)
Elementary Middle School High School Postsecondary

_____Did you often wait until the last minute to do your homework?

_____ Did you have trouble completing and turning in homework?

More information:

Childhood behaviors

Did you have any of the following as a child or teen? Check all that apply.

_____Trouble completing assigned chores

_____Trouble getting ready for school in the morning

_____Struggled to keep room organized/clean

_____Misplaced, lost, or had problems keeping track of your items

_____Forgot school work/items between home and school

_____Needed frequent reminders by parents and/or teachers to complete your work

_____Argued a lot or did not follow the rules.

_____Had problems managing your temper/frequent emotional outbursts

_____Damaged property

_____Had trouble managing personal hygiene (bathing, clean clothes)

More information:

Name:______________________________________

Date of birth:_______________________________

Relationships/social (current and past)

Describe how your symptoms have affected the following relationships, both past and current.

Current or past relationship(s) with spouse/partner or significant other:

____
____
____

Parenting your children:

____
____
____

Family of origin (parents/siblings/grandparents):

____
____
____

Current friendships:

____
____
____

Peer relationships during childhood:

____
____
____

Employer:

____
____
____

Employment history/information

What is your current employment status? (circle)

Full-time Part-time Unemployed Student Disabled Homemaker

If employed, what is your current occupation and job title? ____

How long have you worked at your present job?_________________________________

Name:______________________________________

Date of birth:________________________________

Employment History

Job title / Number of years on job / Reason for leaving

____
____
____
____

What is the longest you have worked at one job?______________________________

Have you ever been fired from a job? ____________________________________

Check any of the following that currently are or have been problems for you at work:

_____Often late
_____Frequent mistakes
_____Often bored
_____Late finishing projects
_____Poor time management
_____Conflict with boss/co-workers
_____Easily distracted
_____Problems with organization
_____Problems learning new material
_____Fired or suspended

More information:

Health issues

Have you ever had any of the following? If yes, please state past or current and any relevant details.

Allergies ____
Serious head injury____
Epilepsy/seizures ____
Significant accidents____
Broken bones____
Headaches ____
Thyroid condition____
Hearing or vision problems ____
Any other medical problems ____

Sleep issues

Check all that apply. If checked, please state past or current and any relevant details.

_____Insomnia (problems getting or staying asleep)
_____Teeth grinding
_____Daytime sleepiness
_____Excessive dreaming/nightmares
_____Snoring
_____Enuresis (bedwetting)

How many hours of sleep do you usually get each night?

Have you ever been tested for a sleep disorder? If yes, please tell us when and the results of the test.

____
____

Name:____

Date of birth:_________________________________

Diet

Please check all that apply.

_____Well-balanced diet (food from each food group at every meal: fruits/veggies, grains, dairy, meat/protein)
_____Eat 3 meals per day
_____Crave sweets _____Often eat at fast food restaurants
_____ Recent appetite change _____Daily caffeine use

More information:

Exercise

How often do you exercise? How long do you exercise for?
_____Daily _____3 to 5 times per week
_____1 to 2 times per week _____No current exercise routine

More information:

Driving

At what age did you get your driver's license?_______________________
Is your current driver's license valid?_______________________________
Have you ever gotten tickets for speeding or other violations? If yes, please describe.
____
____
Have you ever caused an accident or damaged your car while not paying attention?____________________________
Do you get lost easily or often miss turns?____
Do you get road rage?____
Are you usually running late, which causes you to speed?____
Do others feel safe when you are driving?____

Other risky/impulsive behavior

Please check all that apply.

_____ Drug or alcohol use
_____ Risky sexual behaviors (multiple partners, unprotected sex)
_____ Aggressive behavior
_____ Impulsive decision-making (making decisions without thinking about possible side effects or consequences)
_____ Excessive spending or gambling

More information:

Other information

Have you ever been tested (as a child or an adult) for attention or learning problems? If so, please tell us when and the results of the test.____
____
____

Is there any other information that would be helpful for us to know?
____
____
____

Patient signature: ____ Date: __________ Time: __________