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To Whom It May Concern:

Thank you for expressing interest in being evaluated at our office. Enclosed in this packet you will find the following questionnaires and rating scales:

- Adult ADHD Questionnaire
- ADHD RS-IV (for Adolescents & Adults)
- Release of Information
- Please include a copy of your immunization record

There may be additional assessments included in your intake packet if we find it necessary to gather more information.

The purpose of the questionnaire(s) is to gather as much information as possible about your developmental, medical, psychiatric, educational, and social history. The signed Release of Information form gives us permission to exchange information with others.

When you have completed the questionnaire and rating scale, please return them to University Wellness Services between 8:00am and 5:00pm Monday through Friday. If you have had any previous psychological and/or educational testing, please send a copy along as well. Once we have received the completed forms from you and any previous evaluations, we can proceed with the initial appointment.

Again, thank you for contacting us. We strive to make the evaluation process as efficient as possible and welcome any suggestions that you might have. Please do not hesitate to contact us if you need any assistance in completing any of the forms.

Sincerely,

University Wellness Services
Northwest Missouri State University

## Adult Intake Questionnaire

*Please fill out the following questionnaires to the best of your ability. If there is information that you do not want in your record, please refrain from entering it here. Thank you.*

**Patient Identification**

Name:_____ DOB:_____ Age:_____

Address: Phone Work:_____
Home:_____
Cell:_____

**Referral Source**

Address: Phone:_____

**Purpose of Evaluation**

- ☐ Discuss behaviors, possible diagnosis, treatment options
- ☐ Second opinion
- ☐ Medication management

**Current Concerns**

Home ☐ None

School / Academically ☐ None

Employment ☐ None

Relationships / Socially ☐ None

Legally ☐ None

**Past Evaluations** *(if more than one, give most recent)* ☐ None

Date:_____ Location:_____

Name:_____

☐ Psychiatrist ☐ Psychologist ☐ Other:_____

Diagnosis:_____

**Current Diagnosis:**_____

**Current Medications** ☐ None

| *Medication* | *Dose* | *Times/Day* | *Condition* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Prior Psychiatric Medications/Supplements** ☐ None

*Please list all medications/supplements taken alone and all medications taken in combination; including dosages, effectiveness, and any side effects. Please attach another sheet if you need more room.*

| *Dates Taken* | *Name of Medication/s Dosage and Time of Day* | *Effectiveness* | *Side Effects* |
|---|---|---|---|
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**Medical History**

Present Health Concerns: ☐ None

Current Medications *(other than psychiatric medications)* ☐ None

| *Medication* | *Dose* | *Times/Day* | *Condition* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Chronic or Recurrent Medical Conditions: ☐ None

Past Medical Conditions *(not chronic or recurrent)* ☐ None

Past Surgeries: ☐ None

Type: _____ Date: _____

_____ _____

_____ _____

Past Hospitalizations: ☐ None

Reason: _____ Date: _____

_____ _____

_____ _____

Past History of Seizures or Head Trauma: ☐ No ☐ Yes

*If yes, explain:* _____

Primary Care Physician:

Name: _____ Phone: _____

Address:

Date of Most Recent Physical Exam: _____

Current Height: _____ Current Weight: _____

Allergies: ☐ No ☐ Yes: _____

Immunizations: ☐ Up to Date ☐ Not Up to Date – Needs: _____

History of Vision or Hearing Problems: ☐ No ☐ Yes: _____

History of Sleep Problems: ☐ No ☐ Yes: _____

**Habits**

Do you:

Drink coffee, tea, or colas? ☐ No ☐ Yes (specify # per day/week):_____

Smoke? ☐ No ☐ Yes (specify # per day/week):_____

Drink alcohol? ☐ No ☐ Yes (specify # per day/week):_____

Use recreational drugs? ☐ No ☐ Yes (specify # per day/week):_____

Exercise? ☐ No ☐ Yes (Type):_____

Have any hobbies? ☐ No ☐ Yes:_____

**Developmental History**

Are you aware of any difficulties in completing developmental tasks while growing up—such as walking, talking, or toilet training?

☐ No ☐ Yes (Explain):_____

Did you make and keep friends easily? ☐ No ☐ Yes

If no, what problems did you have? _____

**Educational History**

Did you graduate from high school? ☐ No ☐ Yes ☐ GED

How were your grades in Elementary School?_____

How were your grades in Middle and High School?_____

Were you ever diagnosed with a learning disability? ☐ No ☐ Yes (what kind?)_____

Did you receive extra help or services for your learning disability? ☐ No ☐ Yes (specify below)

Describe your academic strengths:

Did you have any behavioral issues in school? ☐ No ☐ Yes (explain below)

Were there recurrent comments the teachers made about you on your grade card or to your parents? Examples:

- ☐ Could do better if tried harder
- ☐ Not motivated
- ☐ Work is inconsistent
- ☐ Is too social, talks too much
- ☐ Has a hard time paying attention in class
- ☐ Is disorganized
- ☐ Other_____

List any degrees earned beyond high school:

| Degree | Major | School | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Employment/Occupational History**

Are you currently employed? ☐ No ☐ Yes

If yes, where? _____

How long? _____

Do you find your job satisfying? ☐ No ☐ Yes

If no, please explain:

List the jobs you have had since completing your education:

| Job | Dates |
|---|---|
| | |
| | |
| | |
| | |

Do you have any work related issues now or in the past? ☐ No ☐ Yes

If yes, please explain:

What would your employers and/or supervisors say about your performance?

Are you or have you ever been in the Military? ☐ No ☐ Yes

**Interpersonal / Social History**

Check any of the following that occurred during your childhood or adolescence?

- ☐ Family problems
- ☐ Afraid to go to school
- ☐ Short attention span
- ☐ Hyperactivity
- ☐ Truancy
- ☐ Running away from home
- ☐ Legal problems
- ☐ Alcohol or drug abuse
- ☐ Abuse (describe below)
  - ☐ Emotional:_____
  - ☐ Physical:_____
  - ☐ Sexual:_____

Please list any other traumatic events you may have suffered:

Please list any current life stresses (relationships, job, school, finances, children):

Describe your current marital status:

☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

Number of times married:_____

With whom do you currently live with?

| Name (First Name) | Relationship | Age | Education/Occupation |
|---|---|---|---|
| | | | |
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| | | | |

How many friends would you describe as close?

☐ None ☐ One ☐ Two ☐ Three ☐ Four or more

How often do you see or talk with your friends? _____

List any activities or organizations that you belong to:

How comfortable are you in social situations?

☐ Very comfortable ☐ Relatively comfortable ☐ Relatively uncomfortable ☐ Very anxious

**Family History**

Please answer the following questions regarding your biological parents to the best of your knowledge.

Were you adopted? ☐ No ☐ Yes

Biological Mother

Age:_____ Occupation:_____

Highest Grade completed in School:_____ ☐ GED ☐ Degree

History of learning problems? ☐ No ☐ Yes (explain):_____

History of behavioral problems? ☐ No ☐ Yes (explain):_____

Medical history: ☐ Negative: _____

Psychiatric history (ADHD, Depression, Bipolar Disorder, Substance Abuse, Anxiety): ☐ Negative

Additional Info:_____

Family history (parents, siblings, nieces/nephews) with medical, psychological, substance abuse, developmental, behavioral, and/or educational problems? ☐ No

Biological Father

Age:_____ Occupation:_____

Highest Grade completed in School:_____ ☐ GED ☐ Degree

History of learning problems? ☐ No ☐ Yes (explain):_____

History of behavioral problems? ☐ No ☐ Yes (explain):_____

Medical history: ☐ Negative: _____

Psychiatric history (ADHD, Depression, Bipolar Disorder, Substance Abuse, Anxiety): ☐ Negative

Additional Info:_____

Family history (parents, siblings, nieces/nephews) with medical, psychological, substance abuse, developmental, behavioral, and/or educational problems? ☐ No

List your brothers and sisters, including yourself, from **oldest** to the **youngest**:

| Name | Age | Sex | Relationship | |
|---|---|---|---|---|
| | | | Close | Distant |
| | | | | |
| | | | | |
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# ADHD RS-IV Inventory (For Adolescents & Adults)

Name:_____ Date of Birth: _____

School:_____ Grade in School:_____ Age:_____ Today's Date:_____

☐ This is the first time I have completed this questionnaire. ☐ I (the patient) completed this form.

☐ I have completed this questionnaire before. (Follow-up) ☐ I am completing this questionnaire as an observer.

| | *N/A - check this column if the question does not apply to you or to your situation. | N/A* | Seldom | Not Too Often | Fairly Often | Very Often |
|---|---|---|---|---|---|---|
| **CARELESSNESS** | | | | | | |
| 1 | Do you make a lot of mistakes in your school work or on the job? | | | | | |
| 2 | Do you rush through work or activities? | | | | | |
| 3 | Do you have trouble with detailed work? | | | | | |
| 4 | Do you not check your work? | | | | | |
| 5 | Do people complain that you are careless? | | | | | |
| 6 | Do you regard yourself as messy or sloppy? | | | | | |
| 7 | Is your desk or work place so messy that you have difficulty finding things? | | | | | |
| **DIFFICULTY SUSTAINING ATTENTION IN ACTIVITIES** | | | | | | |
| 1 | Do you have trouble paying attention when doing such things as watching movies, reading, or attending lectures? | | | | | |
| 2 | Do you have trouble keeping your attention focused on fun activities such as sports or board games? | | | | | |
| 3 | Is it hard for you to keep your mind on school or work? | | | | | |
| 4 | Do you have unusual trouble staying focused on boring or repetitive tasks? | | | | | |
| 5 | Does it take you a lot longer than it should to complete tasks because you can't keep your mind on the task? | | | | | |
| 6 | Does it seem harder for you to complete the same tasks than others who are performing the same task? | | | | | |
| 7 | Do you have trouble remembering what you have read and do you need to re-read the same passage several times? | | | | | |
| **LISTENING** | | | | | | |
| 1 | Do people complain that you don't seem to listen or respond when spoken to or when asked to do tasks? | | | | | |
| 2 | Do people have to repeat directions for you? | | | | | |
| 3 | Do you find that you miss the key parts of conversations because of drifting off in your own thoughts? | | | | | |
| **FOLLOW THROUGH** | | | | | | |
| 1 | Do you have trouble finishing things such as work or chores? | | | | | |
| 2 | Do you leave things half done and start a new project before other projects are complete? | | | | | |
| 3 | Do you need consequences (such as deadlines) to finish? | | | | | |
| 4 | Do you have trouble following instructions (especially complex ones that have multiple steps)? | | | | | |
| 5 | Do you need to write down instructions in order not to forget them? | | | | | |
| **ORGANIZATIONAL SKILLS** | | | | | | |
| 1 | Do you have trouble organizing tasks into ordered steps? | | | | | |
| 2 | Is it hard prioritizing work and chores? | | | | | |
| 3 | Do you seem to need others to plan for you or help you with planning? | | | | | |
| 4 | Do you have trouble with time management? (Meaning using time effectively in a way that serves your needs/goals) | | | | | |
| 5 | Does difficulty in planning lead to procrastination and putting off tasks until the last moment possible? | | | | | |
| **TASKS REQUIRING SUSTAINABLE MENTAL EFFORT** | | | | | | |
| 1 | Do you avoid lengthy assignments, reading, or games because you will not be able to stay focused long enough? | | | | | |
| 2 | Do you have to force yourself to do certain tasks, even though you know that you will eventually have to do them? | | | | | |
| 3 | Do you procrastinate and put off tasks until the last moment possible? | | | | | |
| **LESS IMPORTANT ITEMS** | | | | | | |
| 1 | Do you lose important items such as work papers, school assignments, keys, wallets, coats, and so forth? | | | | | |
| 2 | Do you have to search for important items? | | | | | |
| 3 | Does misplacing important items cause problems for you at home or school or work? | | | | | |
| 4 | Do you need to put items (e.g., glasses, wallet, keys) in the same place each time to avoid losing them? | | | | | |
| **DISTRACTABILITY** | | | | | | |
| 1 | Are you ever very easily distracted by every-day events around you (noise conversation, radio, TV, movement or clutter)? | | | | | |
| 2 | Do you need relative isolation to be able to complete work the way you want to? | | | | | |
| 3 | Can almost anything get your mind off what you are doing, such as work, chores, or if you're talking to someone? | | | | | |
| 4 | Is it hard for you to get back on a task once you have paused or stopped? | | | | | |
| **FORGETFULNESS IN DAILY ACTIVITIES** | | | | | | |
| 1 | Do you forget a lot of things in your daily routine? Like what? Chores? Work? Appointments or obligations? | | | | | |
| 2 | Do you forget to bring things to work, such as work materials or assignments due that day? | | | | | |
| 3 | Do you need to write regular reminders to yourself to do most activities or tasks, otherwise you will forget? | | | | | |

| | *N/A - check this column if the question does not apply to you or to your situation. | N/A* | Seldom | Not Too Often | Fairly Often | Very Often |
|---|---|---|---|---|---|---|
| **STIMULATION** | | | | | | |
| 1 | Can you sit still or are you always moving your hands or feet, or fidget in your chair? | | | | | |
| 2 | Do you tap your pencil on your feet? A lot? Do people notice? | | | | | |
| 3 | Do you regularly play with your hair or clothing? | | | | | |
| 4 | Do you consciously resist fidgeting or squirming? | | | | | |
| **ABILITY TO REMAIN SEATED IN ACTIVITIES THAT REQUIRE THIS** | | | | | | |
| 1 | Do you have trouble staying seated? At work? In class? At home (e.g., watching TV, eating dinner)? In Church or Temple? | | | | | |
| 2 | Do you choose to walk around rather than sit? | | | | | |
| 3 | Do you have to force yourself to remain seated? | | | | | |
| 4 | Is it difficult for you to sit through a long meeting or lecture? | | | | | |
| 5 | Do you try to avoid going to functions that require you to sit still for long periods of time? | | | | | |
| **EXCESSIVE MOTOR ACTIVITY** | | | | | | |
| 1 | Are you physically restless? | | | | | |
| 2 | Do you feel restless inside? A lot? | | | | | |
| 3 | Do you feel more agitated when you cannot exercise on an almost daily basis? | | | | | |
| **ABILITY TO WORK OR PLAY QUIETLY** | | | | | | |
| 1 | Do you have a hard time playing or working quietly? | | | | | |
| 2 | During free time, if you decide to read a book, listen to music, or play a board game, do you get agitated or restless? | | | | | |
| 3 | Do you always need to be busy after work or while on vacation? | | | | | |
| **ON THE GO, "DRIVEN BY A MOTOR"** | | | | | | |
| 1 | Is it hard for you to slow down? | | | | | |
| 2 | Do you feel like you (often) have a lot of energy and that you always have to be moving, are always "on the go"? | | | | | |
| 3 | Do you feel like you're driven by a motor? | | | | | |
| 4 | Do you feel unable to relax? | | | | | |
| **EXCESSIVE TALK** | | | | | | |
| 1 | Do you talk a lot? All the time? More than other people? | | | | | |
| 2 | Do people complain about your talking? Is it a problem? | | | | | |
| 3 | Are you often louder than the people you are talking to? | | | | | |
| **BLURTING OUT** | | | | | | |
| 1 | Do you give answers to questions before someone finishes asking the question? | | | | | |
| 2 | Do you say things before it is your turn? | | | | | |
| 3 | Do you say things that don't fit into the conversation? | | | | | |
| 4 | Do you do things without thinking? A lot? | | | | | |
| **LACK OF PATIENCE** | | | | | | |
| 1 | Is it hard for you to wait your turn (in conversation, in line, while driving)? | | | | | |
| 2 | Are you frequently frustrated with delays? Does it cause problems? | | | | | |
| 3 | Do you put a great deal of effort into planning to not be in situations where you might have to wait? | | | | | |
| **SOCIAL COURTESY** | | | | | | |
| 1 | Do you talk when others are talking, without waiting until you are acknowledged? | | | | | |
| 2 | Do you butt into others' conversations before being invited? | | | | | |
| 3 | Do you interrupt others' activities? | | | | | |
| 4 | Is it hard for you to wait to get your point across in a conversation or at a meeting? | | | | | |