Here is your draft, fully restructured into a professional ADHD assessment report in detailed **narrative format**. I have carefully followed your instructions: no checklist or bullet-style writing, all information retained, and each symptom expanded into functional impact where relevant.

**ADHD Assessment Report**

**Assessment Outcome**

It is our joint opinion that **XXX** meets the diagnostic criteria for **Attention Deficit Hyperactivity Disorder (ADHD)**.

**Assessment Information**

The assessment was carried out via a video consultation. Developmental history information was provided by XXX’s mother. XXX herself was also present during the assessment, and I confirm that I met and interacted with her during the evaluation.

**Who We Assessed**

XXX is a ………….-old girl who currently attends **The B H Academy**, where she is about to enter Year 11. She is described by her parents as a kind, funny, and good-natured young person with a wonderful sense of humour. Despite her many strengths, she has faced ongoing challenges with her mental health and daily functioning.

**Consent**

Parental consent was obtained for this assessment to take place.

**Understanding of Appointment**

XXX’s parents were keen to understand her neurodiversity profile so that the appropriate support can be put in place to help her in both academic and social settings.

**Reason for Referral and Presenting Concerns**

Concerns about XXX first arose in 2020 when she was … years old, as she began to struggle significantly with her mental health. At that time, her difficulties were thought to be related to anxiety and depression, but it was not clear why these conditions had developed. Following a consultation with CAMHS in May 2024, it was suggested that ADHD or autism might be contributing to her difficulties.

XXX’s difficulties include challenges with attention and focus, visible restlessness, and struggles with self-expression. She often finds it difficult to advocate for herself and can be very literal in her understanding, which makes it hard for her to grasp jokes or subtleties in communication. School has been particularly challenging: if the classroom environment becomes too noisy or there are unexpected changes such as a new teacher or seating arrangement, she quickly feels overwhelmed and has difficulty participating in lessons.

She tends to cope by maintaining a very small, close circle of trusted friends, but she finds it difficult to build new relationships. At home, her mood can be unpredictable; at times she is very patient with her younger sister, while on other days she becomes easily irritated and impatient. She does not respond well to being told what to do if the task does not align with her own wishes.

Her school behaviour has been increasingly erratic. She struggles to follow instructions and becomes frustrated quickly, which sometimes escalates into meltdowns. She has received multiple detentions and has been suspended once. Despite support from the school, she frequently cannot manage to attend all of her lessons and often copes with only one or two a day, usually ending the school day in tears and feeling overwhelmed.

Her parents note that XXX masked her difficulties for much of her early life but began to struggle to maintain this from 2020 onwards.

**Past Medical History**

XXX has a history of **anxiety and depression**, …………………………..

Medically, she is otherwise fit and healthy. She has no allergies and her immunisations are up to date. She has had ongoing hearing difficulties, requiring four sets of grommets from age four and is awaiting …………surgery. Her vision is reported to be normal.

**Early Developmental History**

Pregnancy was largely uncomplicated, although her mother reported some bleeding, and XXX was born three days overdue with the umbilical cord around her neck. She was delivered vaginally at term in good condition, weighing 7 pounds 13 ounces. Her mother smoked around 10 cigarettes per day during pregnancy but did not use alcohol or drugs.

As a baby, XXX was breastfed for two weeks. She experienced colic and reflux requiring medication but otherwise thrived.

Developmental milestones were achieved on time. She walked independently at the expected age, spoke at the right age, and did not require speech and language therapy. There was no regression of skills, and toileting was achieved at an age-appropriate stage. She started nursery at 2.5 years old, where no significant concerns were raised about her social, play, or separation abilities.

**Family and Social History**

XXX is one of three children. Tragically, her brother died at six months of age due to trisomy and a congenital heart condition. She has a younger sister, O, aged six, who has also been referred for an ADHD assessment.

Her mother, aged 45, works as a teaching assistant in a primary school. Her father, aged 40, is self-employed in vehicle recovery. There is a family history of neurodiversity, with O being assessed for ADHD, but no other significant family medical history was reported.

The family has also experienced significant life events, including the loss of two grandparents and her father being involved in an accident in 2023.

**ADHD Features**

**Inattention**

XXX is described as being able to focus for extended periods only when the activity is of strong interest, such as baking or watching films. In contrast, she struggles to sustain attention in tasks that she finds less engaging, such as most schoolwork, particularly reading or written assignments. Homework is often avoided, and she requires repeated encouragement to begin and complete tasks.

In the classroom, she is easily distracted by both external stimuli, such as noises in the corridor, and her own thoughts. Teachers note that she often gazes out of the window, especially in subjects she dislikes. She has difficulty listening when spoken to directly, often zoning out or daydreaming unless the subject matter is of high personal interest.

She frequently forgets daily tasks such as bringing items to school or completing chores, often requiring multiple reminders. Her memory for instructions is poor, and she easily forgets what she is supposed to be doing midway through a task. She leaves personal belongings behind at school or friends’ houses and spends considerable time searching for misplaced items.

She struggles to follow through on instructions, often starting tasks but becoming sidetracked and failing to complete them. She requires step-by-step reminders to complete basic routines, such as brushing her teeth or dressing for school.

XXX also shows poor organisational skills. Her belongings are often disorganised, she is regularly late, and she experiences difficulty planning ahead. Mornings are particularly chaotic, requiring a great deal of parental input to get her ready for school. She tends to procrastinate, leaving work until the last minute, and rushes to finish tasks without paying attention to detail, leading to careless mistakes.

**Hyperactivity**

XXX displays significant restlessness. She often bounces her legs, fiddles with her fingers, and fidgets constantly, especially in situations where sitting still is expected. Although she can manage to sit through mealtimes, she struggles to remain seated afterwards. In restaurants and cinemas she frequently shifts position, jiggles, or fidgets, although walking helps her calm down.

She describes feeling restless internally, with racing thoughts and a sense of never being able to fully relax. At home she tends to talk excessively, often dominating conversations with her parents.

**Impulsivity**

XXX struggles with waiting her turn, particularly in queues, and quickly becomes restless and impatient. During Years 8 and 9 she was noted to be highly disruptive in school, regularly interrupting, reacting impulsively, and receiving detentions almost daily. Strategies introduced more recently, such as movement breaks, have improved this somewhat.

She has a tendency to act quickly on impulses, feeling a strong urge to carry out an idea as soon as it occurs to her, although she remains aware of risks and avoids unsafe behaviour. Emotional regulation is a particular difficulty: she shifts rapidly from calm to upset, often becoming tearful or angry within moments. She is highly sensitive and can be triggered into distress quickly. Although she previously displayed physical and verbal aggression in Year 9, this has improved with support and is no longer a major issue.

**Self-Care and Independence**

XXX is able to manage her self-care independently but occasionally requires reminders to stay on task and complete routines.

**Social Functioning**

XXX does not have difficulties with social communication in terms of speaking; she is talkative and enjoys chatting. However, she is selective about friendships, maintaining two close friends while finding it harder to engage more broadly.

**Restricted and Repetitive Interests**

XXX shows some restricted interests, including a strong attachment to the Harry Potter series and repeatedly listening to the same music.

**Diet and Growth**

XXX has a selective diet but eats a reasonable variety of foods, enjoying vegetables as well as junk food. She is growing well and has no major dietary concerns.

**Sleep**

XXX struggles with sleep initiation. She goes to bed at around 10:00 pm but often does not fall asleep until between 10:30 pm and midnight. Her sleep is frequently interrupted, and she wakes feeling tired.

**Mental Health and Wellbeing**

XXX has a past history of anxiety, depression, and self-harm, with previous hospital admission. At present, her mood and wellbeing have stabilised, and over the last 12 weeks her mental health has been good.

**Observations from Clinical Interview**

During the consultation XXX was appropriately dressed, appeared healthy and well-nourished, and presented in a positive mood. She engaged well in the assessment, spoke clearly, and contributed her perspective alongside her mother.

**Diagnostic Conclusion**

Based on the detailed developmental history, school reports, screening measures including Conners questionnaires and QB check, and direct clinical observation, XXX meets the DSM-5 criteria for **Attention Deficit Hyperactivity Disorder (ADHD)**.

Her presentation is characterised by persistent difficulties with inattention, hyperactivity, impulsivity, emotional regulation, and executive functioning, which have had a significant and sustained impact on her academic performance, social relationships, and daily life.

It is therefore our clinical opinion that XXX meets the threshold for an ADHD diagnosis.

Would you like me to now create a **final version in your usual medical letter/report format** (with professional headings, signature line, and a concluding recommendations section), so it is directly ready to be shared with parents and school?