

Brief Semi-Structured Interview for ADHD in Adults

Patient Name _____ Date _____

1. Inquire about the current presence and severity of core ADHD symptoms. (Have patient complete an ADHD symptom checklist.)

Yes	No	Symptoms Present
<input type="checkbox"/>	<input type="checkbox"/>	Inattention
<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity
<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity

If present, age at which symptoms first appeared: _____

Would others who know you agree that these symptoms are present? _____

2. Inquire about the degree to which ADHD symptoms impair performance in school, work, or social relationships.

Mild	Moderate	Severe	Domains of Impairment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Impairment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work Impairment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship Impairment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: _____

Would others who know you agree that these symptoms impair your performance? _____

3. Inquire about the presence of symptoms of other psychiatric disorders.

Yes	No	Other Symptoms of Psychiatric Disorders	Yes	No	Other Symptoms of Psychiatric Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Dysthymia	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use/Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Generalized Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Anger management
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder/Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Anti-social behavior
<input type="checkbox"/>	<input type="checkbox"/>	Social Anxiety/Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	Post-Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cognitive impairments
<input type="checkbox"/>	<input type="checkbox"/>	Academic/learning problems	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify below)

4. Inquire about past psychiatric history (e.g., previous diagnosis of ADHD or other psychiatric disorders).

Yes	No	Previous Psychiatric Diagnosis	Yes	No	Previous Psychiatric Diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use/Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Anger management
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Anti-social behavior
<input type="checkbox"/>	<input type="checkbox"/>	Social Anxiety/Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	Post-Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cognitive impairments
<input type="checkbox"/>	<input type="checkbox"/>	Academic/learning problems	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify below)

5. Inquire about current or past mental health treatment.

6. Inquire about any significant physical health problems (past and present).