Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's 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
Part A					
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?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

OCD Screener

Obsessive Compulsive Disorder Screening Questions

Yes	No	
☐	☐	Do you have thoughts that bother you or make you anxious and that you can't get rid of regardless of how hard you try?
☐	☐	Do you have a tendency to keep things extremely clean or to wash your hands very frequently, more than other people you know?
☐	☐	Do you check things over and over to excess?
☐	☐	Do you have to straighten, order, or tidy things so much that it interferes with other things you want to do?
☐	☐	Do you worry excessively about acting or speaking more aggressively than you should?
☐	☐	Do you have great difficulty discarding things even when they have no practical value?

Patient Name _____ Date _____

Obsessive Compulsive Screening Checklist

People with OCD usually have difficulty with some of the following activities. Answer each question by circling the appropriate number next to it.

0 No problem with activity—takes me same time as average person. I do not need to repeat or avoid it.

1 Activity takes me twice as long as most people, or I have to repeat it twice, or I tend to avoid it.

2 Activity takes me three times as long as most people, or I have to repeat it three or more times, or I usually avoid it.

Score	Activity
0 1 2	Taking a bath or shower
0 1 2	Washing hands and face
0 1 2	Care of hair (eg, washing, combing, brushing)
0 1 2	Brushing teeth
0 1 2	Dressing and undressing
0 1 2	Using toilet to urinate
0 1 2	Using toilet to defecate
0 1 2	Touching people or being touched
0 1 2	Handling waste or waste bins
0 1 2	Washing clothing

Score	Activity
0 1 2	Washing dishes
0 1 2	Handling or cooking food
0 1 2	Cleaning the house
0 1 2	Keeping things tidy
0 1 2	Bed making
0 1 2	Cleaning shoes
0 1 2	Touching door handles
0 1 2	Touching own genitals, petting, or sexual intercourse
0 1 2	Throwing things away
0 1 2	Visiting a hospital

Score	Activity
0 1 2	Turning lights and taps on or off
0 1 2	Locking or closing doors or windows
0 1 2	Using electrical appliances (eg, heaters)
0 1 2	Doing arithmetic or accounts
0 1 2	Getting to work
0 1 2	Doing own work
0 1 2	Writing
0 1 2	Form filling
0 1 2	Mailing letters
0 1 2	Reading

_____ **Total**

Total scores >10 increase the possibility of obsessive compulsive disorder (OCD), and further evaluation is recommended. Totals >20 are highly suggestive of OCD.

...ington, DC: American Psychiatric Press; 1985.

QUESTIONNAIRE PART A

PATIENT SELF-EVALUATION

Patient's name: **Date:**

Instructions: The questions below are designed to help your doctor evaluate patients with anxiety symptoms. Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder—only an evaluation by a physician can make this determination. Answer the questions below as accurately as you can; this will help your doctor make a diagnosis.

Please circle YES or NO for the following questions, based on your experience in the past MONTH:

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:

- Concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS? YES NO
- Overconcern with keeping objects (clothing, groceries, tools) in perfect order or arranged exactly? YES NO
- Images of death or other horrible events? YES NO
- Personally unacceptable religious or sexual thoughts? YES NO

Have you worried a lot about terrible things happening, such as:

- Fire, burglary or flooding of the house? YES NO
- Accidentally hitting a pedestrian with your car or letting it roll down a hill? YES NO
- Spreading an illness (giving someone AIDS)? YES NO
- Losing something valuable? YES NO
- Harm coming to a loved one because you weren't careful enough? YES NO

Have you worried about acting on an unwanted and senseless urge or impulse, such as:

- Physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests? YES NO

Have you felt driven to perform certain acts over and over again, such as:

- Excessive or ritualized washing, cleaning or grooming? YES NO
- Checking light switches, water faucets, the stove, door locks or the emergency brake? YES NO
- Counting; arranging; evening-up behaviors (making sure socks are at same height)? YES NO
- Collecting useless objects or inspecting the garbage before it is thrown out? YES NO
- Repeating routine actions (in/out of chair, going through doorway, relighting cigarette) a certain number of times or until it feels *just right*? YES NO
- Needing to touch objects or people? YES NO
- Unnecessary rereading or rewriting; reopening envelopes before they are mailed? YES NO
- Examining your body for signs of illness? YES NO
- Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (those that start with "D" signify death) that are associated with dreaded events or unpleasant thoughts? YES NO
- Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly? YES NO

If you answered YES to TWO OR MORE questions, please continue with Part B on the next side

QUESTIONNAIRE PART B

PATIENT SELF-EVALUATION

Instructions: The following questions refer to the repeated thoughts, images, urges or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer.

Circle the most appropriate number from 0 to 4.

In the past month...					
1. On average, how much *time* is occupied by these thoughts or behaviors each day?	0 None	1 Mild (less than 1 hour)	2 Moderate (1 to 3 hours)	3 Severe (3 to 8 hours)	4 Extreme (more than 8 hours)
2. How much *distress* do they cause you?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme (disabling)
3. How hard is it for you to *control* them?	0 Complete control	1 Much control	2 Moderate control	3 Little control	4 No control
4. How much do they cause you to *avoid* doing anything, going anyplace or being with anyone?	0 No avoidance	1 Occasional avoidance	2 Moderate avoidance	3 Frequent and extensive avoidance	4 Extreme avoidance (house-bound)
5. How much do they *interfere* with school, work or your social or family life?	0 None	1 Slight interference	2 Definitely interferes with functioning	3 Much interference	4 Extreme interference (disabling)

For physician use:
Sum on Part B (Add items 1 to 5):

Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder—only an evaluation by a physician can make this determination.

Mood Disorder Questionnaire

Patient _____ Score _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem