PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

9601 BAPTIST HEALTH DRIVE, SUITE 1050
LITTLE ROCK, AR 72205

Patient Name: ______________________________ Social Security Number:_____-_____-______

Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married / Single / Divorced / Widow

Language: _______________ Race: _______________ Ethnicity: Hispanic / Non-Hispanic / Other

Address: ____
(Street) (City/State/Zip)

Primary Phone: (____) ________-____________ Secondary Phone: (____) ________-____________

Would you be interested in having communications sent to you via your email? (examples: appointment reminders, administrative updates and health bulletins)

Yes No

Email: ____

Employer Name: ______________________________ Phone: (____) ________-____________

Employer Address: ____
(Street) (City/State/Zip)

Primary Care Physician: ______________________________ ______________________
(Name) (Phone)

How did you hear about our practice? ____

Pharmacy Name: ____
(Phone)

Person responsible for bill or parent/guardian *(Complete only if different from patient)*

Guarantor Name: ______________________________ Social Security Number:_____-_____-______

Relationship to Patient: (please check) ( ) self ( ) spouse ( ) parent Date of Birth: _____/_____/_____

Address: ____
(Street) (City/State/Zip)

Phone: (____) ________-____________ Email: ______________________________

Employer Name: ______________________________ Phone: (____) ________-____________

Employer Address: ____
(Street) (City/State/Zip)

Who to call for an emergency? *(Not at same address as patient)*

Name: ______________________________ Relationship to Patient: ____________________

Primary Phone: (____) ________-____________ Secondary Phone: (____) ________-____________

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Psychiatric Associates of Arkansas, PLLC. I further acknowledge that I am financially responsible for payment whether or not service is covered by my insurance policy.

______________________________ ______________________
Signature of Patient or Personal Representative Date

PSYCHIATRIC ASSOCIATES OF ARKANSAS

Health Survey

Patient Name: ____ Pulse: ____________

Height: ______________ Weight: ______________ Blood Pressure: Systolic ________ Diastolic ________

Smoker: Current ________ / Former ________ / Never ________

Please review the categorized list of symptoms below, and circle any and all that may apply to you.

1. **General**: fever, chills, sweats, appetite loss, fatigue, malaise, weight loss
2. **Vision**: blurring, double vision, irritation, discharge, vision loss, eye pain, light sensitivity
3. **Ears/Nose/Throat**: ear pain or discharge, ringing in ears, hearing loss, nasal obstruction/discharge, nosebleeds, sore throat, hoarseness, difficulty swallowing
4. **Cardiovascular**: chest pain, irregular heartbeat, fainting, shortness of breath, difficulty breathing, ankle swelling
5. **Respiratory**: cough, excess sputa, coughing up blood, wheezing, shortness of breath
6. **Gastrointestinal**: nausea, vomiting, diarrhea, constipation, changed bowel habits, abdominal pain, bloody stool, tarry stool, yellowing skin or eyes
7. **Genitourinary**: vaginal discharge, incontinence, painful urination, bloody or discolored urine, urinary frequency, vaginal bleeding, abnormal menstrual bleeding, abnormal menstrual pain, lack of menstrual periods, pelvic pain
8. **Musculoskeletal**: back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis
9. **Skin**: rash, itching, dryness, lesions
10. **Neurologic**: weakness, tingling, numbness, seizures, fainting, tremor, dizziness
11. **Psychiatric**: depression, anxiety, memory loss, paranoia, voices, suicidal ideation
12. **Endocrine**: cold intolerance, heat intolerance, excessive thirst, excessive urination, weight change
13. **Hematologic/Lymphatic**: bruising, bleeding, enlarged nodes
14. **Allergic/Immunologic**: rash, hay fever, repeated infections, HIV exposure

PSYCHIATRIC ASSOCIATES OF ARKANSAS

9601 Baptist Health Dr., Suite 1050
Little Rock, AR 72205
(501) 228-7400

NEW PATIENT HISTORY FORM

NAME:						**DATE:**
Referring physician:				*Consent to send evaluation?*	□ YES	□ NO
Consent for PAA to use e-prescribing for transmitting prescriptions to your pharmacy:					□ YES	□ NO
Signature for the consents listed above:						
GENERAL INFORMATION						
Instructions: *Please fill this out as fully as you comfortably can. The more information we have about you, the better we can serve you.*						
Date of Birth			Age			
Male □	Female □	Single □	Married □	Partner □	Divorced□	Widow/er □
Height	Weight		Blood Pressure (last known)			
LIST MEDICATION ALLERGIES & TYPES OF REACTIONS TO THEM:						
Are you pregnant? □yes □no	If yes, are you taking folic acid (800 mcg daily)? □yes □no					
If applicable, list birth control method:						
Contacts and Contact Information:						
Please list the phone number(s) or email address we may use to leave a message for you or contact you:						
Phone number(s), including area codes:						
Email address(es):						
Due to HIPAA regulations about protecting your health information, please list the people (spouse, adult child, care-giver, etc.) you give us permission to talk with regarding your health issues:						
Current Problem(s)						
Please write briefly what problems you are having and what you we can do for you:						
Have you had thoughts of suicide? □yes □no If yes, please explain:						

Please place a check mark by any of the following you have been having problems with:		
□ Difficulty sleeping	□ Decreased appetite	□ Increased appetite
□ Loss of sense of humor	□ Less ability to enjoy regular activities	□ Tearfulness
□ Lack of concentration	□ Irritability	□ Loss of energy
□ Lowered self esteem	□ Less interest in daily grooming (bathing, shaving, wash hair, etc)	□ Generalized anxiety
□ Anxiety/ panic attacks	□ Mania	□ Hearing voices
□ Eating disorder	□ Obsessive thoughts	□ Compulsive behavior

Are any of the following areas of your life particularly stressful to you? (Check all that apply)			
□ Marriage/relationship	□ Health	□ Legal problems	□ Employment
□ Financial problems	□ Family problems	□ Sexual issues	□ Violence

Please explain:

Psychiatric History

Have you ever been treated for a psychiatric illness (depression, anxiety, bipolar, etc.?)	□ YES	□ NO
Have you ever been treated in a psychiatric hospital or inpatient unit?	□ YES	□ NO

If yes to either of the above questions, please list doctor's names, hospitals, and dates of treatment:

Psychiatric History, continued

Have you had any of the following?

Neurological Exam	□YES	□ NO
Psychiatric Exam	□YES	□ NO
Psychological Testing	□YES	□ NO
Professional counseling/psychotherapy	□YES	□ NO

If you answered YES to any of the above, please list the names of the doctor or therapist and dates seen:

Psychiatric Evaluation: Psychiatric Medications

Have you ever taken medicines for depression, anxiety, or any other mental illness?	□YES	□ NO

If yes, please check off psychiatric medicines you have taken in the past or are taking now:

Medication	Dose	Current?	Took when & how long?	Side Effects? What?	Helpful?
Prozac					
Paxil					
Zoloft					
Celexa					
Lexapro					
Effexor					
Wellbutrin					
Symbyax					
Cymbalta					
Remeron					
Serzone					
Pamelor					
Norpramin					
Prestiq					
Trazodone					
Viibryd					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Xanax					
Ativan					
Klonopin					
Valium					
Vistaril					
Tranxene					
Buspar					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Rozerem					
Ambien					
Lunesta					
Sonata					
Restoril					
Amitriptyline					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Adderall					
Vyvanse					
Ritalin					
Concerta					
Strattera					
Nuvigil					
Provigil					
Kapvay					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Lyrica					
Saphris					
Fanapt					
Lithium					
Depakote					
Tegretol					
Lamictal					
Topomax					
Seroquel					
Risperdol					
Zyprexa					
Geodon					
Abilify					
Clozaril					
Latuda					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Namenda					
Aricept					
Exelon					

Stressors

Stressors

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family	◯	◯	◯	◯
Friends	◯	◯	◯	◯
Relationships	◯	◯	◯	◯
Educational	◯	◯	◯	◯
Economic	◯	◯	◯	◯
Occupational	◯	◯	◯	◯
Housing	◯	◯	◯	◯
Legal	◯	◯	◯	◯
Health	◯	◯	◯	◯

Substance History: Substances Used

Substance Abuse History

Do you have a history of any recreational drug use?

◯ Yes

◯ No

If YES, please fill out the table below to the best of your knowledge:

Substance(s) Used:	YES	NO	Age of First Use	Age of Last Use	How was it taken?	Amount per day	Days per month
Amphetamines / Speed	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Barbiturates / Downers	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Opiates	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Cocaine	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Psychedelics (e.g. LSD, Ecstasy, bath salts)	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Inhalants (e.g. glue, aerosols)	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Cannabis / Marijuana / Hashish	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Benzodiazepines	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
PCP	◯	◯			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		

Substance History: Treatment History

Substance Abuse Treatment History

Did you receive any treatment for substance abuse?

- ◯ Yes
- ◯ No

If YES, please fill out the table below to the best of your knowledge:

Treatment Type	YES	NO	How many episodes of treatment?	Age of first treatment?	Age of last treatment?	Any additional treatment information?
Inpatient	◯	◯				
Intensive Outpatient	◯	◯				
Outpatient	◯	◯				
12-Step Program	◯	◯				

Substance History: Consequences of Substance Abuse

Consequences of Substance Abuse

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please check all that apply)

- ☐ No consequences

- ☐ Felt that you needed to cut down on your drinking
- ☐ Been annoyed by others criticizing your drinking
- ☐ Felt guilty about drinking
- ☐ Needing a drink first thing in the morning

- ☐ Increased tolerance
- ☐ Withdrawal (shakes, sweating, nausea, rapid heart rate)
- ☐ Seizures
- ☐ Blackouts
- ☐ Effects on physical health
- ☐ Using/consuming more than intended
- ☐ Unintentional overdose
- ☐ DUI
- ☐ Arrests
- ☐ Physical fights or assaults
- ☐ Relationship conflicts
- ☐ Problems with money
- ☐ Job loss or problems at work/school

Other:

Medical History

List the names of physicians you have seen recently, what you saw them for and when:

Have you had any recent laboratory work done?	☐ YES	☐ NO

If yes, who ordered it and when was it done?

List previous medical or surgical hospitalizations:

Year	Hospital	City & State	Reason

Regular Medicines (List)	Dose	Prescribing Doctor

What over-the-counter medicines/vitamins/herbs do you take?

Have you had any serious illnesses? *(Check all that apply).*

☐ Cancer	☐ Thyroid Problems	☐ Migraine Headaches	☐ Asthma
☐ Diabetes	☐ Bowel Problems	☐ Stomach Ulcers	☐ Hepatitis
☐ HIV	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol
☐ Seizures	☐ Long Term Pain	☐ Stroke	☐ Head Injury

☐ Other:

Family History

Family History					
Number of pregnancies:					
Names and ages of children:					
Names and ages of your brothers/sisters:					
Do any of your children or siblings have a problem with a depression, anxiety, or any other psychiatric illness?				□YES	□ NO
If yes, who and what illness?					
Do any of your children, or brothers or sisters have a problem with alcohol or other drug abuse?				□YES	□ NO
If yes, who and what substances were abused?					
Is your Mother living?	□YES	□ NO	Is your Father living?	□YES	□ NO
Are they married to each other?	□YES	□ NO	Your age, if they divorced?		
Mother: psychiatric problems?	□YES	□ NO	Alcohol or substance abuse?	□YES	□ NO
Father: psychiatric problems?	□YES	□ NO	Alcohol or substance abuse?	□YES	□ NO
Please describe:					
Extended family members with psychiatric problems or alcohol/substance abuse?				□YES	□ NO
Please describe:					

Social History

Social History			
How would you describe your childhood?	□Happy?	□Not Happy?	What Happened?
Were you physically abused growing up?		□YES	□ NO
If yes, by whom?			
Were you sexually abused growing up?		□YES	□ NO
If yes, by whom?			
Highest grade completed in school?			
Did you serve in the military?	□YES	□ NO	
What branch?	How long?	Type of discharge?	
How many times have you been married?		If currently married, how long?	
Where are you currently employed?			
How long have you worked there?			
If less than one year, where else have you worked and for how long?			
Are you currently on work disability or FMLA?		□YES	□ NO
If yes, what doctor has had you out on disability?			
How long have you been off work? (Give specific dates)			
Are you requesting the physician you are seeing today continue this disability?		□YES	□ NO

Habits

Do you smoke cigarettes?	□YES	□ NO	*If yes, how much per day?*
Do you drink alcoholic beverages?	□YES	□ NO	*If yes, how often do you drink? Check box below:*

□Daily	□3-5 times per week	□1-2 times per week
□1-3 times per month	□1-3 times per six months	□1-3 times per year

If you drink alcoholic beverages, how much will you drink at each event?		
Have you used other drugs? (Crystal methamphetamine, cocaine, marijuana, etc.)	□YES	□ NO
If yes, what drugs, how often, how much?		
Have you ever been in treatment for alcohol or other drug abuse?	□YES	□ NO
If yes, where and when did you receive treatment?		
Have you ever suffered any consequences of alcohol or other drug abuse such as legal problems (DWI, DUI), public intoxication, possession of drugs, dealing drugs, etc.), medical (DT's, seizures, stomach problems, hepatitis, pancreatitis, AIDS, etc.), social (marital problems, job problems, bankruptcy, loss of friends and family, etc.)?	□YES	□ NO
Please explain:		

Do you drink caffeine?	□YES	*If yes, how much per day?*	□ NO

Past Psychiatric History: Suicide/Self Harm

Suicide/Self-Harm History

Have you ever tried to harm or kill yourself?

- ◯ Yes
- ◯ No

Was your intent to die?

- ◯ Yes
- ◯ No

Elaborate below, if desired:

How many times in your life has this occurred?

Most Severe Episode

Please describe your most severe episode including date, method, and consequences:

Month: - Select One -

Year:

Method: - Select One -
Other:

Consequences: - Select One -
Other:

Most Recent Episode

Please describe your most recent episode including date, method, and consequences:

Month: - Select One -

Year:

Method: - Select One -
Other:

Consequences: - Select One -
Other:

Violence History Assessment

Have you had any history of violent behavior?

- ◯ Yes
- ◯ No

If YES, please elaborate below:

General Social History

Which options below best describes your social situation?

- [ ] Supportive social network
- [ ] Few friends
- [ ] Substance-use based friends
- [ ] No friends
- [ ] Distant from family of origin
- [ ] Family conflict

Other:

What is your current marital status? (If a minor, indicate marital status of your parents)

- Select One -

What is the status of your intimate relationship?

- Select One -

What is the satisfaction level of your intimate relationship?

- Select One -

What is your sexual orientation?

- Select One -

What is your current living situation?

- Select One -

Who do you currently live with? (Please check all that apply)

- [ ] Live alone
- [ ] Roommates
- [ ] Parent(s)
- [ ] Partner/Spouse
- [ ] Children

Other:

Do you currently participate in spiritual activities?

—

What is your current occupation status?

- Select One -

What is your current yearly income?

- Select One -

General Social History 1

What is your longest period of continuous employment? (Please include dates and description)

Employment start:

Employment end:

Description:

What is your longest period of continuous unemployment? (Please include dates and description)

Unemployment start:

Unemployment end:

Description:

General Social History 2

Social History: Menstruation and Pregnancy

Menstruation and Pregnancy History

At what age did you begin menstruation?

Which of these best describe your premenstrual symptoms?

- [ ] None of these
- [ ] Dysphoria
- [ ] Cramps
- [ ] Appetite change
- [ ] bloating
- [ ] Sleep disturbance

Have you ever been pregnant?

- ( ) Yes
- ( ) No

If YES, how many times?

Have you ever given birth?

- ( ) Yes
- ( ) No

If YES, how many times?

Have you had any miscarriages?

- ( ) Yes
- ( ) No

If YES, how many times?

Have you had any abortions?

- ( ) Yes
- ( ) No

If YES, how many times?

Psychiatric Associates of Arkansas, PLLC
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Little Rock, Arkansas 72205
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Adult Symptom Screener

(ages 15 and older)

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling down, depressed, or hopeless	☐	☐	☐	☐
2. Little interest or pleasure in doing things	☐	☐	☐	☐
3. Feeling nervous, anxious or on edge	☐	☐	☐	☐
4. Not being able to stop or control worrying	☐	☐	☐	☐

The following questions relate to your experiences over the last 6 months:

	Yes	No
1. In the past 6 months, did you ever have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy?	☐	☐
2. In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?	☐	☐
3. Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?	☐	☐

Please respond to the degree that the following problems have bothered you during the past week.

	Not at all	A little bit	Somewhat	Very much	Extremely
1. Fear of embarrassment causes me to avoid doing things or speaking to people.	☐	☐	☐	☐	☐
2. I avoid activities in which I am the center of attention.	☐	☐	☐	☐	☐
3. Being embarrassed or looking stupid are among my worst fears.	☐	☐	☐	☐	☐

Please answer each question to the best of your ability.

	Yes	No
1. Have you experienced any of the following traumatic events: natural disaster (e.g., flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g., car accident, plane crash); physical assault (e.g., being attacked, beaten up); sexual assault (e.g., rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a war-zone; life-threatening illness or injury; sudden, unexpected death of or injury to someone close to you; or serious injury, harm, or death to someone else that you witnessed or caused?	☐	☐
2. Has this event caused any significant problems or symptoms that lasted for more than a month?	☐	☐

Please answer each question to the best of your ability.

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 you didn't really miss it?	☐	☐
...you were much 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 much 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 into trouble?	☐	☐

The following questions relate to your eating habits:

	Yes	No
1. When you eat, do you make yourself sick because you feel uncomfortably full?	☐	☐
2. Do you ever worry that you have lost control over how much you eat?	☐	☐
3. Have you recently lost more than 14 pounds in a 3 month period?	☐	☐
4. Do you believe yourself to be fat when others say you are too thin?	☐	☐
5. Would you say that food dominates your life?	☐	☐

	Yes	No
Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?	☐	☐

The following questions relate to your alcohol and substance use.

	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How often do you have a drink of alcohol?	☐	☐	☐	☐	☐

	1-2	3-4	5-6	7-9	10 or more
How many drinks containing alcohol do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often do you have six or more drinks on one occasion?	☐	☐	☐	☐	☐

	Yes	No
In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	☐	☐

Please answer the questions below, rating yourself on each of the criteria shown using the scale provided. As you answer each questions, select the option that best describes how you have felt and conducted yourself over the last 6 months.

	Never	Rarely	Sometimes	Often	Very often
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?	☐	☐	☐	☐	☐

The questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were your usual self.

	Yes	No
1. Do you find that most people will take advantage of you if you let them know too much about you?	☐	☐
2. Do you generally feel nervous or anxious around people?	☐	☐
3. Do you avoid situations where you have to meet new people?	☐	☐
4. Do you avoid getting to know people because you're worried that they may not like you?	☐	☐
5. Has avoidance of getting to know people due to fear of being disliked affected the number of friends that you have?	☐	☐
6. Do you keep changing the way you present yourself to people because you don't know who you really are?	☐	☐
7. Do you often feel like your beliefs change so much that you don't know what you really believe any more?	☐	☐
8. Do you often get angry or irritated because people don't recognize your special talents or achievements as much as they should?	☐	☐

	Yes	No
Have you had any unusual experiences such as hearing voice, seeing visions, or having ideas you later found out were not true?	☐	☐
Have you had any other experience, such as mind reading, ESP, thoughts being controlled by others, seeing things on TV that refer to you specifically?	☐	☐

The Patient Health Questionnaire (PHQ-9)

Patient Name ______________________________ Date of Visit ______________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? ____

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

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**
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 A
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?					

	Never	Rarely	Sometimes	Often	Very Often
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?					

Part B