ADD/ADHD Questionnaires

Identifying Information

Name: _____ _____
Last First

Sex: F Age: 33

Phone: (_____)_____ Date: _____

Address: _____ _____ _____
Street City Zip

Medication: ____ None ____ Rated on meds ____ Rated off meds

List of Medications Taken: _____
_____
_____

Background Information

If the person has completed his/her education, please select one of the options from the "Completed Education" section. Otherwise, select from the "Current Grade Level" section.

Completed Education **OR** **Current Grade Level**

____ 8th Grade or less

____ 9-11 Grade

____ High School Graduate

____ Technical School Graduate

____ Some College

____ College Graduate

____ Master's Degree or higher

____ Unknown

____ Pre-K

____ Kindergarten

____ 1st Grade

____ 2nd Grade

____ 3rd Grade

____ 4th Grade

____ 5th Grade

____ 6th Grade

____ 7th Grade

____ 8th Grade

____ 9th Grade

____ 10th Grade

____ 11th Grade

____ 12th Grade

____ College Freshman

____ College Sophomore

____ College Junior

____ College Senior

____ Graduate School

____ Unknown

Father's Education Level

____ 8th Grade or less

____ 9-11 Grade

____ High School Graduate

____ Technical School Graduate

____ Some College

____ College Graduate

____ Master's Degree or higher

____ Unknown

Mother's Education Level

____ 8th Grade or less

____ 9-11 Grade

____ High School Graduate

____ Technical School Graduate

____ Some College

____ College Graduate

____ Master's Degree or higher

____ Unknown

Ethnicity ____ African American ____ Hispanic ____ White

____ Asian ____ Other ____ Unknown

State _____ **Examiner ID** _____

Health Questionnaire

Please answer the questions as accurately as possible. All of the information is confidential. You must answer all of the questions to proceed. If you are not sure or don't know the answer, then please select Don't Know as your choice.

Have you EVER seen a doctor for a brain injury or possible concussion?	Yes	No	Don't Know
Have you EVER seen a doctor for seizures or the treatment of epilepsy?	Yes	No	Don't Know
Are you CURRENTLY seeing a psychotherapist or counselor?	Yes	No	Don't Know
Are your CURRENTLY taking any prescribed medication for ADD/ADHD?	Yes	No	Don't Know
Are you CURRENTLY taking any other prescribed medication, except for birth control?	Yes	No	Don't Know
Do you believe you have a reading learning disability?	Yes	No	Don't Know
Do you believe you have a math learning disability?	Yes	No	Don't Know
Were you hyperactive when you were 12 years old or less?	Yes	No	Don't Know
Do you believe you have ADD/ADHD?	Yes	No	Don't Know
Have you been diagnosed as having ADD/ADHD by a healthcare professional?	Yes	No	Don't Know
Do you feel stressed, unhappy or worried a lot?	Yes	No	Don't Know
Do you have problems remembering what others tell you?	Yes	No	Don't Know
If others try to explain something to you, do you have difficulty understanding them?	Yes	No	Don't Know
When it is important to pay attention, can you stay focused?	Yes	No	Don't Know

Self-Report Scale Questionnaire

Please read each question below carefully. Using your judgment, choose the response which best describes how you felt or what you experienced during the test. There are no right or wrong answers. Please answer all of the twelve questions.

Did you talk or mumble to yourself during the test?	Not At All	Some	A Lot	Very Much
Did you think about other things during the test?	Not At All	Some	A Lot	Very Much
Was it hard to keep looking only at the screen during the test?	Not At All	Some	A Lot	Very Much
Did you feel drowsy or sleepy during the test?	Not At All	Some	A Lot	Very Much
Were you confused about when it was correct to respond?	Not At All	Some	A Lot	Very Much
Was it harder to pay attention towards the end of the test?	Not At All	Some	A Lot	Very Much
Did you fiddle or play with anything during the test?	Not At All	Some	A Lot	Very Much
Were you feeling tired or drained at the end of the test?	Not At All	Some	A Lot	Very Much
Did you make a lot of mistakes during the test?	Not At All	Some	A Lot	Very Much
Did taking the test make you feel stressed, upset, or frustrated?	Not At All	Some	A Lot	Very Much
Was it hard to sit still during the test?	Not At All	Some	A Lot	Very Much
Was the test boring?	Not At All	Some	A Lot	Very Much
Did you make an effort to perform your best on this test?	Not At All	Some	A Lot	Very Much
If you took the test again, do you think you would do better	Not At All	Some	A Lot	Very Much

Behavioral Scale Questionnaire

Indicate below the number of times the specific behaviors described below were observed. A description of twelve behaviors is listed below. Please rate as accurately as you can in accordance with the Test Observation Rating Guidelines.

During the warm-up instructions, they clicked or played with the mouse or iPad.	0	1	2	3	4	5	6	7+
They had problems responding correctly to the practice test instructions.	0	1	2	3	4	5	6	7+
Talked, hummed or made sounds to themselves during the test.	0	1	2	3	4	5	6	7+
Fiddled or played with the mouse or iPad during the test.	0	1	2	3	4	5	6	7+
Switched the hand or finger that they used to make a test response.	0	1	2	3	4	5	6	7+
Became upset, stressed, or frustrated during the test.	0	1	2	3	4	5	6	7+
Wiggled, fidgeted or were restless during the test.	0	1	2	3	4	5	6	7+
Talked about unrelated topics to the examiner during the test.	0	1	2	3	4	5	6	7+
Looked around the room while taking the test.	0	1	2	3	4	5	6	7+
Asked to stop the test or asked when the test would be done.	0	1	2	3	4	5	6	7+
Became drowsy, sleepy, or closed their eyes during the test.	0	1	2	3	4	5	6	7+
Stopped responding to test stimuli for 15 seconds or more.	0	1	2	3	4	5	6	7+