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Interview Form and Rating Scale for ADHD Adults

The following is the interview form that we use at the adult ADHD clinic at the University of Massachusetts Medical Center for evaluating adult referrals to our clinic. It is quite useful for the assessment of adults and the preparation of subsequent clinic reports. It can also be used to establish a database in a computer file for later clinical research projects.

Also included here are the Self-Rating Symptom Checklist and Physical Complaints Checklist for conducting a quick screening of psychiatric and physical symptoms about which adult patients are currently concerned. The Patient's Behavior Checklist is also included to allow an assessment of adult ADHD symptoms. The items included in the scale were drawn from the DSM-III-R and were suggested by Rachel Gittelman and Paul Wender. These scales do not yet have norms for judging the degree of deviance of a patient's ratings but instead should simply be used as information-gathering tools about the client's current complaints.

SEMISTRUCTURED INTERVIEW FOR ADULT ADHD

Name: _____ Date: _____

Patient No: _____ Time: _____

Date of Birth: _____ Interviewer: _____

Age: _____

1. What led you to seek an evaluation for ADHD now?

2. What is your understanding of this disorder?

3. What do you know about the treatment of this disorder?

4. Do you know anyone who has been diagnosed with this disorder?
    1. Yes
    2. No
    3. Not Sure

5. If "Yes", how were they treated for this disorder?
    1. Ritalin or methylphenidate
    2. Unknown medication or other medication only
    3. Therapy (Group or individual) only
    4. Not sure how they were treated
    5. Other

Comments:

6. What are your greatest concerns about your behavior now?

7. When would you say these problems began? (Circle any one)
    1. 0-7 years
    2. 8-12 years
    3. 13-15 years
    4. 16-21 years
    5. 22 years to present

8. Now I'm going to ask you some symptoms and I'd like you to tell me if they were ever more of a problem for you than for other people in your peer group.

Symptom	Yes	No	Now it is: Same	Better	Worse	Comments
a. Fidgetiness or feeling restless						
b. Difficulty remaining satisfied						
c. Being easily distracted						
d. Difficulty waiting your turn.						
e. Blurting out answers before the question is completed						
f. Difficulty following through on or completing tasks						
g. Sustaining attention in tasks						

Symptom	Yes	No	Same	Better	Worse	Comments
h. Frequently shifting from one task to another						
i. Difficulty doing tasks alone						
j. Talking too much						
k. Interrupting or intruding on others						
l. Not listening to others						
m. Losing important things or forgetting a lot						
n. Engaging in physically daring activities						
o. Always on the go, as if driven by a motor						
p. Making decisions too quickly or acting too quickly						
q. Impatient						

9. Did you ever seek treatment for these problems before? (Circle one)
   a. Yes
   b. No

If yes, when and where did you seek treatment?

What was the recommended treatment and the outcome?

10. Did your parents ever take you to see anyone about these problems when you were a child or adolescent?
   a. Yes
   b. No
   c. Not sure

11. Did your parents complain that you were difficult to control as a child?
   a. Yes
   b. No
   c. Not sure

   If yes, during what ages did they have this complaint? (Circle all that apply)
   a. 0-7 years
   b. 8-12 years
   c. 13-15
   d. 16-21 years
   e. 22+ years

12. Now I am going to ask you some questions about school. What is the highest level of school that you have completed?
   a. 6th grade or less
   b. 7th or 8th grade
   c. Freshman or sophomore
   d. Junior high school
   e. Graduated from high school
   f. 1 or 2 years college
   g. 3 or 4 years college
   h. Postgraduate

13. Did you have any trouble starting school in kindergarten or first grade?

14. Did you ever repeat a grade?
   a. Yes
   b. No

If yes, which grade(s) did you repeat? _____

15. Were you in any special classes in school?
   a. Yes
   b. No

If yes, what kind of classes? _____

16. How would you describe your grades in school?
   a. Average
   b. Better than average
   c. Worse than average

17. What was your best subject in school? _____

18. What was your worst subject in school? _____

19. Did your teachers think you did as well as you could?
    a. Yes
    b. No
    c. Not sure

20. Were you ever truant from school?
    a. Yes
    b. No

If yes, how often and during which grades?

21. Were you ever expelled or suspended from school?
    a. Yes
    b. No

22. Did you ever get into physical fights at school?
    a. Yes
    b. No

If yes:

I. During which grades did you get into fights?
    a. K-6th grade
    b. 7th or 8th grade
    c. High school
    d. Other

II. How many times did you get into fights?
    a. One time
    b. Two to five times
    c. Six to ten times
    d. More than ten times

III. Did you sometimes start the fight?
    a. Yes
    b. No
    c. Not sure

IV. Did you ever use a weapon in a fight?
    a. Yes
    b. No

23. Did you ever run away from home overnight?
    a. Yes
    b. No
    If yes:
    I. How many times did you run away?
        a. Once
        b. Two to five times
        c. Six to ten times
        d. More than ten times
    II. What was the longest durationg you ran away from home?
        a. One night
        b. Two to five nights
        c. Six to ten nights
        d. Longer than ten nights

24. Did you ever get in trouble for stealing or damaging property as a child or teenager?
    a. Yes
    b. No

25. Have you ever been arrested or in trouble with the law?
    a. Yes
    b. No

If yes:

I. How many traffic tickets (not parking tickets) have you ever gotten
    a. None
    b. One
    c. Two to three
    d. Four to five

II. How many car accidents have you ever been in?
    a. None
    b. One
    c. Two
    d. Three
    e. Four or more

If no: Why don't you have a driver's license?

27. Do you have problems with your temper?
    a. Yes
    b. No

If yes, please explain:

28. Did you ever have problems with your temper?
    a. Yes
    b. No
    c. Not sure

29. Have you ever lost your temper enough to hurt anyone or damage any property?
    a. Yes
    b. No

If yes, please explain:

30. Do other people complain about your temper?
    a. Yes
    b. No
    c. Not sure

31. How would you describe your mood most of the time?
    a. Normal and fairly stable
    b. Anxious or nervous
    c. Depressed, sad, or blue
    d. Labile; moos changes a lot
    e. Other: _____

32. Do you have a problem with your sleep?
    a. Yes
    b. No

33. Do you have any problems with your weight?
    a. Yes
    b. No

If yes, please explain:

34. Do you ever use any diet preparations?
    a. Yes
    b. No

If yes, which ones?

35. How much alcohol do you drink *in a week?*
    a. I never drink
    b. 0-1 drinks
    c. 2-4 drinks
    d. 5-10 drinks
    e. More than 10

    Details:

36. Did you ever drink more heavily?
    a. Yes
    b. No

If yes, please explain:

37. Have you ever used any drugs recreationally?
    a. Yes
    b. No

DRUG:	USED:	FREQUENCY

    a. Pot, marijuana, hashish, grass
    b. Amphetamines, stimulants, uppers, speed
    c. Barbiturates, sedatives, downers, sleeping pills, Seconal, Quaaludes
    d. Tranquilizers, Valium, Librium
    e. Cocaine, crack
    f. Heroin
    g. Opiates other than heroin (iodine, Demerol, Morphine, methadone, Sarvon, opium)
    h. Psychedelics (LSD, mescaline, peyote, DMT, PCP)
    i. Other (Specify)

38. Do you use any drugs recreationally now?
    a. Yes
    b. No
    If yes, what and how often?

39. Have you ever misused prescription drugs?
    a. Yes
    b. No
    If yes, please explain:

Past Psychiatric History

40. Have you ever seen a counselor or psychiatrist before?
    a. Yes
    b. No

If yes, please explain:

41. Have you ever been hospitalized for a psychological or psychiatric problem?
    a. Yes
    b. No

If yes, please explain:

42. Have you ever had problems with depression?
    a. Yes
    b. No

If yes, please explain:

43. Have you ever had any problems with anxiety?
    a. Yes
    b. No

If yes, please explain:

Past Medical History

44. Do you have any current medical problems?
    a. Yes
    b. No

If yes, please explain:

45. Have you ever been hospitalized medically?
    a. Yes
    b. No

If yes, please explain:

46. Have you ever had any heart problems?
    a. Yes
    b. No

If yes, please explain:

47. Have you ever had any liver disease?
    a. Yes
    b. No

If yes, please explain:

48. Have you ever had glaucoma?
    a. Yes
    b.
    c. No

If yes, please explain:

49. Have you ever had any seizures?
    a. Yes
    b. No

If yes, please explain:

50. Do you have high blood pressure?
    a. Yes
    b. No

If yes, please explain:

51. Are you ever troubled by chest pain or shortness of breath?
    a. Yes
    b. No

If yes, please explain:

52. Have you ever had an injury to your head?
    a. Yes
    b. No

If yes, please explain:

53. Have you ever lost consciousness?
    a. Yes
    b. No

If yes, what was your first memory afterwards?
Please explain:

54. Have you ever had encephalitis or a brain infection?
    a. Yes
    b. No

If yes, please explain:

55. Have you ever had or do you now have any tics or unusual movements of your body?
    a. Yes
    b. No

If yes, please explain:

56. Have you ever had or do you have any vocal tics, or do you make any unusual noises (Tourette's Syndorme)?
    a. Yes
    b. No

If yes, please explain:

57. Are you right-sided or left-sided (Insert R, L, Amb. As appropriate)
    a. Writing: _____ c. Throwing: _____
    b. Kicking: _____ d. Sighting: _____

58. Have you ever had any problems with your thyroid gland?
    a. Yes
    b. No

If yes, please explain:

Developmental History

59. As far as you know, were there any problems with you mother's pregnancy or delivery of you?
    a. Yes
    b. No

If yes, please explain:

60. As far as you know, did you walk, talk, and sit up on time?
    a. Yes
    b. No

If no, please explain:

61. Did you have any childhood illnesses?
    a. Yes
    b. No

If yes, please explain:

62. Did you have normal relationships with your peers when you were a child?
    a. Yes
    b. No

If no, please explain:

Sexual History (For Females Only)

63. Are you sexually active?
    a. Yes
    b. No

64. Are you trying to get pregnant?
    a. Yes
    b. No

65. Do you intend to get pregnant within the next 5 years?
    a. Yes
    b. No

66. Are you using any birth control?
    a. Yes
    b. No

67. Are you currently nursing?
    a. Yes
    b. No

Medications

68. Do you take any medications?
    a. Yes
    b. No

If yes, please explain:

69. Do you take any over the counter medications?
    a. Yes
    b. No

If yes, please explain:

70. (For women) Do you use birth control pills?
    a. Yes
    b. No

Allergies

71. Do you have any allergies?
    a. Yes
    b. No

If yes, please explain:

72. Do you have any other allergies?
    a. Yes
    b. No

If yes, please explain:

Family History

73. Are there any medical illnesses that run in your family?
    a. Yes
    b. No

If yes, please explain:

74. Is there anyone in your family who has had problems with anxiety or depression?
    a. Yes
    b. No

If yes, please explain:

75. Is there anyone in your family who has abused alcohol or other drugs?
    a. Yes
    b. No

If yes, please explain:

76. Is there anyone in your family who has had any psychiatric illnesses?
    a. Yes
    b. No

If yes, please explain:

77. Is there anyone in your family who has been in trouble with the law?
    a. Yes
    b. No

If yes, please explain:

78. Is there anyone in your family who has had seizures or other neurological problems?
    a. Yes
    b. No

If yes, please explain:

79. Is there anyone in your family who has had Tourette's syndrome or vocal tics?
    a. Yes
    b. No

If yes, please explain:

80. Is there anyone in your family who had a movement disorder or any unusual movements?
    a. Yes
    b. No

If yes, please explain:

81. Is there anyone in your family who has had heart problems?
    a. Yes
    b. No

If yes, please explain:

82. Is there anyone in your family who has high blood pressure?
    a. Yes
    b. No

If yes, please explain:

83. Is there anyone in your family who has had attentional problems?
    a. Yes
    b. No

If yes, please explain:

84. Is there anyone in y our family who has had learning disabilities?
    a. Yes
    b. No

If yes, please explain:

Social History

85. How much do you smoke?
    a. Never smoked
    b. Have quit for more than a year
    c Have quit for less than a year
    d. Less than half a pack per day (ppd)
    e. Half to one ppd
    f. One or two ppd
    g Two or more ppd

86. How much caffeine do you think you drink, including caffeinated tea or soda?

a. None
b. 1-2 cups per day
c 3-4 cups per day
d. 5-6 cups per day
e. 7-10 cups per day
f 11+ cups per day

87. Can you tell me your work history, starting as far back as you can remember?

88. Have you ever served in the military?

a. Yes
b. No

If yes please explain (higest rank, honors, duties, discharge status):

89. What is your current marital status?

a. Never Married
b. Married
c. Separated
d. Divorced
e. Widowed

90. Are you currently in an intimate relationship?

a. Yes
b. No

If yes, please answer the following:

a. Less than three months
b. 3-6 months
c. 7 months-1 year
d. 1-5 years
e. 5-10 years
f. 10+ years

91. Do you have trouble in your relationships with others?

a. Yes
b. No

If yes, please explain:

92. How many intimate relationships have you had that lasted more than 3 months?

a. None
b. One or two
c. Three or four
d. Five or more

93. I have asked you a lot of questions. Can you think for a minute and tell me if there are any other problems you have that might be related to what you came here for?

SELF-RATING SYMPTOM CHECKLIST FOR ADHD ADULTS

NAME: _____ **DATE:** _____

Please rate the degree to which you have been experiencing the following problems during the PAST WEEK by marking an "X" across each of the following lines:

	Not a Problem									Severe Problem
1.Anxiety	1	2	3	4	5	6	7	8	9	10
2. Depression	1	2	3	4	5	6	7	8	9	10
3. Disturbing thoughts	1	2	3	4	5	6	7	8	9	10
4. Fears/Fearfulness	1	2	3	4	5	6	7	8	9	10
5. Angry outbursts	1	2	3	4	5	6	7	8	9	10
6. Eating Problems	1	2	3	4	5	6	7	8	9	10
Specify: _____										
7. Sleep Problems	1	2	3	4	5	6	7	8	9	10
Specify: _____										
8. Fatigue	1	2	3	4	5	6	7	8	9	10
9. Sexual Problems	1	2	3	4	5	6	7	8	9	10
Specify: _____										
10. Alcohol and/or drug problems	1	2	3	4	5	6	7	8	9	10
Specify: _____										
11. Stress	1	2	3	4	5	6	7	8	9	10

	Not a Problem									Severe problem 12.
Work/School Problems	1	2	3	4	5	6	7	8	9	10
13. Family Problems	1	2	3	4	5	6	7	8	9	10
14. Child Rearing Problems	1	2	3	4	5	6	7	8	9	10
15. Problems getting along with others	1	2	3	4	5	6	7	8	9	10
16. Violence	1	2	3	4	5	6	7	8	9	10

Specify: _____

17. Health Problems	1	2	3	4	5	6	7	8	9	10

Specify: _____

18. Legal Problems	1	2	3	4	5	6	7	8	9	10
19. Financial Problem	1	2	3	4	5	6	7	8	9	10
20. Other problems	1	2	3	4	5	6	7	8	9	10

Specify: _____

21. Other Problems	1	2	3	4	5	6	7	8	9	10

Specify: _____

22. Other Problems	1	2	3	4	5	6	7	8	9	10

Specify: _____

Please circle the numbers of *UP TO THREE* problems that you consider to be your MAIN problem(s).

PHYSICAL COMPLAINTS CHECKLIST FOR ADHD ADULTS

Name: _____

Date: _____

Below is a list of symptoms that some people have. Beside each item indicate how often each is a problem for you.

Symptoms	Never	Less than 4times/year	Less than Once/month	Less than Once/week	1-3 times/week	Nearly Daily
Headaches						
Trouble Sleeping						
Irritable, nervous						
Stomach Upset						
Aches and pains (Not back aches)						
Backache						
Rapid Heartbeat						
Dizziness, lightheadedness						
Vomiting, nausea						
Diarrhea						
Constipation						
Weakness						
Tired during the day						
Poor appetite						
Blurred vision						
Dry mouth						
Confusion						

PATIENT'S BEHAVIOR CHECKLIST FOR ADHD ADULTS

Name: _____

Date: _____

Below is a list of problems and behaviors that ome patients have. Beside each item indicate how much of a problem each one is for you in *your* opinion

Behavior	Not at all	Just a little	Pretty Much	Very much
Physical restlessness				
Mental restlessness				
Easily distracted				
Impatient				
"Hot" or explosive temper				
Unpredictable behavior				
Difficulty completing tasks				
Shifting from one task to another				
Difficulty sustaining attention				
Impulsive				
Talks too much				
Difficulty doing tasks alone				
Often interrupts others				
Doesn't appear to listen to others				
Loses a lot of things				
Forgets to do a lot of things				
Engages in physically daring activities				
Always on the go, as if driven By a motor				