

## **ADHD Patient Checklist for Teenagers**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Grade Level: \_\_\_\_\_

These checklist inquires about lifelong behaviors. Answer YES only if the particular behavior has consistently impaired your functioning as long as you can remember. If your answers tend to be “sometimes,” answer NO instead.

	Yes	No
For your entire life, have you consistently had trouble paying attention to details or made careless errors in your work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always had difficulty concentrating on tasks that you find boring or uninteresting?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often daydream or seem not to listen when people speak to you directly?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always had difficulty finishing projects you've started?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty organizing your work or become disorganized if not strictly following a plan or list?	<input type="checkbox"/>	<input type="checkbox"/>
Do you procrastinate or put off undesirable tasks until the last possible moment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always had a tendency to lose things necessary to accomplish your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always been easily distracted by unimportant sounds and events around you?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always been forgetful (e.g. names, assignments)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always had difficulty sitting still or fidgeted excessively (even though you can now consciously control it)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always had difficulty staying seated? (e.g. do you have difficulty sitting through a class, movie, or religious service)?	<input type="checkbox"/>	<input type="checkbox"/>
For as long as you can remember, have you been restless (e.g. unconsciously patted your foot, not been able to get comfortable sitting in a chair or lying in bed)?	<input type="checkbox"/>	<input type="checkbox"/>
For your entire life, have you had significant difficulty relaxing or slowing down enough to do leisure activities quietly?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always been described as “high energy” or “always on the go”?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find that you talk excessively or often lose track of what you're saying in conversations?	<input type="checkbox"/>	<input type="checkbox"/>
For your entire life, have you had a pattern of blurting out answers before questions are completed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you always been impatient or had difficulty waiting your turn in group situations (e.g. waiting in line at the grocery store or driving in traffic)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently interrupt or intrude on others (e.g. butt into conversations, games)?	<input type="checkbox"/>	<input type="checkbox"/>

Check the box that best describes how you have felt and conducted yourself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have difficulty getting things in order when you have to do a task that requires organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have problems remembering appointments or obligations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you fidget or squirm with your hands or feet when you have to sit down for a long period of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel overly active and compelled to do things, like you were driven by a motor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>