

ADHD Patient Checklist – Parents Observation

Name: _____ DOB: _____

Parent Name: _____ Grade Level: _____

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

	Yes	No
For his/her entire life, has he/she consistently had trouble paying attention to details or made careless errors in his/her work?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always had difficulty concentrating on tasks that he/she finds boring or uninteresting?	<input type="checkbox"/>	<input type="checkbox"/>
Does he/she often daydream or seem not to listen when people speak to him/her directly?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always had difficulty finishing projects he/she has started?	<input type="checkbox"/>	<input type="checkbox"/>
Does he/she have difficulty organizing work or become disorganized if not strictly following a plan or list?	<input type="checkbox"/>	<input type="checkbox"/>
Does he/she procrastinate or put off undesirable tasks until the last possible moment?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always had a tendency to lose things necessary to accomplish daily activities?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always been easily distracted by unimportant sounds and events around him/her?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always been forgetful (e.g. names, assignments)?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always had difficulty sitting still or fidgeted excessively (even though he/she can now consciously control it)?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always had difficulty staying seated? (e.g. does he/she have difficulty sitting through a class, movie, or religious service)?	<input type="checkbox"/>	<input type="checkbox"/>
For as long as you can remember, has he/she always been restless (e.g. unconsciously patted his/her foot, not been able to get comfortable sitting in a chair or lying in bed)?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always had significant difficulty relaxing or slowing down enough to do leisure activities quietly?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always been described as "high energy" or "always on the go"?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find that he/she talks excessively or often loses track of what others are saying in conversations?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always had a pattern of blurting out answers before questions are completed?	<input type="checkbox"/>	<input type="checkbox"/>
Has he/she always been impatient or had difficulty waiting turns in group situations (e.g. waiting in line at the grocery store or driving in traffic)?	<input type="checkbox"/>	<input type="checkbox"/>
Does he/she 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 your son or daughter has conducted himself/herself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often
How often does he/she 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 does he/she have difficulty getting things in order when he/she has to do a task that requires organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often does he/she have problems remembering appointments or obligations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When he/she has a task that requires a lot of thought, how often does he/she avoid or delay getting started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often does he/she fidget or squirm with his/her hands or feet when he/she has 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 does he/she feel overly active and compelled to do things, like he/she were driven by a motor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>