

## CADDRA ADHD ASSESSMENT TOOLKIT (CAAT) FORMS

*It is recommended that physicians complete an assessment form (A), a screener (S) and at least one rating scale (R). For children, the CADDRA Teacher Assessment Form (T) is also suggested; for adults, a collateral rating scale is helpful. Follow-up forms (F) are also recommended but a baseline of the chosen should be carried out initially.*

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Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## CADDRA ADHD ASSESSMENT FORM

### Identifying Information

<b>Patient:</b>		<b>Date of Birth:</b>	<b>Date seen:</b>
<b>Age:</b>	<b>Gender:</b> <input type="checkbox"/> m <input type="checkbox"/> f	<b>Grade</b> (actual/last completed):	
<b>Current Occupation:</b> <input type="checkbox"/> student <input type="checkbox"/> unemployed <input type="checkbox"/> disability occupation:			
<b>Status:</b> <input type="checkbox"/> child/adolescent <i>OR</i> adult <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> common-law <input type="checkbox"/> separated <input type="checkbox"/> divorced			
<b>Ethnic Origin:</b> ( <i>check all that apply</i> ) <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> African-American <input type="checkbox"/> Native			
<b>Other person providing collateral:</b>			<b>Patient's phone no:</b>

### Demographics

	<b>Biological Father</b> (if known)	<b>Biological Mother</b> (if known)	<b>Spouse/Partner</b> (if applicable)
<b>Name</b>			
<b>Occupation</b>			
<b>Highest education</b>			
<b>Adopted:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Age of Adoption:</b>	<b>Country of Adoption:</b>	
<b>Number of biological and/or half siblings:</b>			
	<b>Stepfather</b> (if applicable)	<b>Stepmother</b> (if applicable)	<b>Other Guardian</b> (if applicable)
<b>Name</b>			
<b>Occupation</b>			
<b>Highest education</b>			
<b>Number of step-siblings:</b>			
<b>Custody</b> (circle custodial parent)	<b>Time with bio Father</b>	<b>Time with bio Mother</b>	<b>Time with step family</b>
<b>Language</b>	<b>At home:</b> <input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> At school _____		
<b>Children</b> (if applicable)	<b>Number of biological:</b>	<b>Number of step children:</b>	
<b>Names and ages</b>			



Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

**Medical History**

<b>Allergies:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes    (Details):
<b>Cardiovascular medical history:</b> <input type="checkbox"/> hypertension <input type="checkbox"/> tachycardia <input type="checkbox"/> arrhythmia <input type="checkbox"/> dyspnoea <input type="checkbox"/> fainting <input type="checkbox"/> chest pain on exertion <input type="checkbox"/> other
<b>Specific cardiovascular risk identified:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes    (Details):
<b>Positive lab or EKG findings:</b>

<b>Positive medical history:</b>	<input type="checkbox"/> In utero exposure to nicotine, alcohol or drugs	<input type="checkbox"/> Stigmata of FAS/FAE	<input type="checkbox"/> History of anoxia/perinatal complications
<input type="checkbox"/> Developmental delays	<input type="checkbox"/> Coordination problems	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Lead poisoning
<input type="checkbox"/> Neurofibromatosis	<input type="checkbox"/> Myotonic dystrophy	<input type="checkbox"/> Other genetic syndrome	<input type="checkbox"/> Hearing/visual problems
<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Growth delay	<input type="checkbox"/> Anemia
<input type="checkbox"/> Traumatic brain injury	<input type="checkbox"/> Seizures	<input type="checkbox"/> Enuresis	<input type="checkbox"/> Injuries
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Tourette's/tics	<input type="checkbox"/> Enlarged adenoids or tonsils	<input type="checkbox"/> Asthma
<input type="checkbox"/> Sleep disorders	<input type="checkbox"/> Secondary symptoms to medical causes	<input type="checkbox"/> Medical complications of drug/alcohol use	
<b>Other/details:</b>			

**Medication History**

<b>Extended health insurance:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes    (Details):			
<input type="checkbox"/> Public <input type="checkbox"/> Private insurance		Coverage for psychological treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Adherence to treatment/attitude towards medication:</b> Difficulty swallowing pills: <input type="checkbox"/> No <input type="checkbox"/> Yes (If applicable) Contraception: <input type="checkbox"/> No <input type="checkbox"/> Yes    (Details):			
<b>Current medications</b>	<b>Dose</b>	<b>Duration Rx</b>	<b>Outcome and side effects</b>
<b>Previous medications</b>	<b>Dose</b>	<b>Duration Rx</b>	<b>Outcome and side effects</b>

Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## Physical Examination

Practice guidelines around the world recognize the necessity of a physical exam as part of an assessment for ADHD in order to rule out organic causes of ADHD, rule out somatic sequelae of ADHD, and rule out contraindications to medications. While this physical exam follows all the usual procedures, several specific evaluations are required. These include, but are not limited to:

### Rule out medical causes of ADHD-like symptoms

- Hearing and vision assessment
- Thyroid disease
- Neurofibromatosis (cafe au lait spots)
- Any potential cause of anoxia (asthma, CF, cardiovascular disease)
- Genetic syndromes and facial or dysmorphic characteristics
- Fetal alcohol syndrome: growth retardation, small head circumference, smaller eye openings, flattened cheekbones and indistinct philtrum (underdeveloped groove between nose and upper lip)
- Physical abuse: unset fractures, burn marks, unexplained injuries
- Sleep disorders: enlarged tonsils and adenoids, difficulty breathing, sleep apnea
- Growth delay or failure to thrive
- PKU, heart disease, epilepsy and unstable diabetes can all be associated with attention problems
- Head trauma.

Medical history/lab work provides information on maternal drinking in pregnancy, sleep apnea, failure to thrive, lead poisoning, traumatic brain injury.

### Rule out sequelae of ADHD

- Abuse
- High pain threshold
- Irregular sleep, delayed sleep phase, short sleep cycle
- Comorbid developmental coordination disorder, evidenced by motor difficulties in doing routine tasks such as getting on the exam table
- Picky eater: will not sit to eat
- Evidence of injuries from poor coordination or engagement in extreme sports

### Rule out contraindications to medication:

- Glaucoma
- Uncontrolled hypertension
- Any evidence of significant cardiovascular abnormality

<b>Date of last physical exam:</b>	<b>By who:</b>
<b>Abnormal findings last exam:</b>	

## Current Physical Exam

System	Done		Normal		Findings (Details of Abnormality)
	No	Yes	No	Yes	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GI and GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebrovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immunol. & Hematological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrinological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dysmorphic facial features	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Weight:</b> In children: percentile	<b>Height:</b> In children: percentile	<b>Head Circum:</b> (In children only)	<b>BP:</b>	<b>Pulse:</b>
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<b>Positive Findings on Observation:</b> (Details)
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## Psychiatric History

Assessed in childhood/adolescence/adulthood? <input type="checkbox"/> No <input type="checkbox"/> Yes		By whom:
Previous diagnoses:		
Previous suicidal attempts or violent gestures toward others: <input type="checkbox"/> No <input type="checkbox"/> Yes	Details:	
Psychological treatments: <input type="checkbox"/> No <input type="checkbox"/> Yes		
Previous psychiatric evaluation/hospitalization: <input type="checkbox"/> No <input type="checkbox"/> Yes		

## Developmental History

<b>Pregnancy Problems:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Delivery <input type="checkbox"/> on time <input type="checkbox"/> Early (# of weeks: _____ ) <input type="checkbox"/> Late (# of weeks: _____ ) <input type="checkbox"/> forceps used <input type="checkbox"/> Caesarean section <input type="checkbox"/> breech	Details:
<b>Difficulties gross motor: crawl, walk, two-wheeler, gym, sports:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Difficulties Fine motor: tracing, shoe laces, printing, writing:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Language difficulties: first language, first words, full sentences, stuttering</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Odd behaviours noted:</b> (e.g. rocking, flapping, no eye contact, odd play, head banging etc) <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Temperament:</b> (eg. difficult, willful, hyper, easy, quiet, happy, affectionate, calm, self soothes, intense)	
<b>Parent description of child's temperament:</b>	
<b>Learning Disorder identified:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> dyslexia <input type="checkbox"/> dysorthographia <input type="checkbox"/> dyscalculia <input type="checkbox"/> dsyphasia <input type="checkbox"/> other: _____	

## Family History in First Degree Relatives

<b>Childhood temperament of the biological parents, if known:</b> (e.g. internalizing versus externalizing)	
<b>Father:</b>	<b>Mother:</b>
<b>Positive family history of:</b>	
<input type="checkbox"/> ADHD (probable) <input type="checkbox"/> Autism Spectrum Disorders <input type="checkbox"/> Bipolar <input type="checkbox"/> Sleep Disorders <input type="checkbox"/> Legal Convictions	<input type="checkbox"/> ADHD (confirmed) <input type="checkbox"/> Congenital Disorders <input type="checkbox"/> Psychosis <input type="checkbox"/> Tourette's/Tics
<input type="checkbox"/> Learning Disorders <input type="checkbox"/> Anxiety <input type="checkbox"/> Personality Disorders <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Retardation <input type="checkbox"/> Depression <input type="checkbox"/> Suicide <input type="checkbox"/> Alcohol/Drug Problems
<input type="checkbox"/> History of early cardiac death	<input type="checkbox"/> Known arrhythmias <input type="checkbox"/> Hypertension
<b>Details:</b>	

## Functioning and Lifestyle Evaluation

General Habits (depending on the subject's age, some may not apply). Give frequency and/or details:			
Exercise			
Nutrition			
Self care, personal hygiene			
Adequate leisure activity			
Sleep Routine and Quality of Sleep	Bedtime: # Sleep hours:	Time to fall asleep: Melatonin: <input type="checkbox"/> No <input type="checkbox"/> Yes Dose:	Wake up time:
Sleep Problems? (BEARS)	Bedtime resistance: <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive daytime sleepiness: <input type="checkbox"/> No <input type="checkbox"/> Yes Awakening: <input type="checkbox"/> No <input type="checkbox"/> Yes	Regularity: <input type="checkbox"/> No <input type="checkbox"/> Yes Snoring: <input type="checkbox"/> No <input type="checkbox"/> Yes	

## Important Risk Factors to Identify

Risk Factor	No	Yes	Details and Attitude towards Change
Excessive screen time	<input type="checkbox"/>	<input type="checkbox"/>	
Accident-prone	<input type="checkbox"/>	<input type="checkbox"/>	
Extreme sports	<input type="checkbox"/>	<input type="checkbox"/>	
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Financial	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	
Parenting	<input type="checkbox"/>	<input type="checkbox"/>	
Family conflict	<input type="checkbox"/>	<input type="checkbox"/>	
Legal	<input type="checkbox"/>	<input type="checkbox"/>	
Discipline	<input type="checkbox"/>	<input type="checkbox"/>	
Witness to violence	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Foster placements	<input type="checkbox"/>	<input type="checkbox"/>	
Significant losses	<input type="checkbox"/>	<input type="checkbox"/>	
Illness	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Current Functioning at Home</b> (depending on age, some may not apply). <b>Give frequency and/or details:</b>	
<b>Family/patient strengths</b>	
<b>Stressors within the family</b>	<b>Past:</b>
	<b>Present:</b>
<b>Family atmosphere</b>	
<b>Morning routine</b>	
<b>Attitudes towards chores</b> (adult: doing housework)	
<b>Attitudes towards rules</b> (adult: able to set/follow rules)	
<b>Engagement in family fun</b>	
<b>Discipline in the family</b> (adult: parenting abilities)	
<b>Relationship to siblings</b> (adult: partner relationship)	
<b>Parent/spouse frustrations</b>	

<b>Social Functioning</b> (depending on age, some may not apply). <b>Give frequency and/or details:</b>	
<b>Patient's strengths:</b>	
<b>Hobbies, activities</b>	
<b>Friends</b> (e.g. play dates, parties, social events)	
<b>Social skills</b> (e.g. social cues compassion, empathy)	
<b>Humour</b>	
<b>Anger management</b> (e.g. aggression, bullying)	
<b>Emotional intelligence</b> (e.g. emotional control, awareness)	
<b>Sexual identity</b>	

Functioning at School (if not at school, indicate where academic history took place and if there were difficulties)		
School name	<input type="checkbox"/> English Second Language <input type="checkbox"/> Individual Education Plan <input type="checkbox"/> Specialized Class <input type="checkbox"/> Specialized Designation <b>Details:</b>	
	<b>Kindergarten to Grade 8</b>	<b>High School</b>
Report card grades		
Report card comments		
Behaviour problems		
Peer relations		
Teacher-child relationships		
Teacher-parent relationships		
Homework attitudes		
Organizational skills		
Achieving potential/difficulties		
Written output		
Accommodations		
Tutoring and/or Learning assistance		
Assistive Technology		
College/University		
Accommodations		
Achieving potential/difficulties		

Functioning at Work (depending on the subject's age, some may not apply) <b>Frequency and/or details:</b>	
Current employment status:	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Contract <input type="checkbox"/> Disability
Vocational Assessment:	<input type="checkbox"/> No <input type="checkbox"/> Yes   If yes, suitable jobs:
# of past jobs:	<b>Length of longest employment:</b>
Work strengths:	
Work weaknesses:	
Complaints:	
Workplace accommodations:	
Other information about work:	

**RATING SCALES:** Administer one or more of the relevant rating scales to the parent, teacher or patient

**STEP ONE: Check the ADHD scale(s) used**

<b>ADHD symptoms in childhood:</b>	<input type="checkbox"/> ADHD Checklist	<input type="checkbox"/> SNAP-IV	<input type="checkbox"/> Other
<b>Current ADHD symptoms:</b>	<input type="checkbox"/> ADHD Checklist <input type="checkbox"/> SNAP- IV (for children)	<input type="checkbox"/> Weiss Symptom Record (WSR) <input type="checkbox"/> ASRS (for adults)	<input type="checkbox"/> Other

The ADHD Checklist can retrospectively be used to assess childhood ADHD symptoms (in adults), for current symptoms and for follow-up (all ages)

**STEP TWO: Fill in the result of the scale**

<b>SYMPTOM SCREENER</b> (enter the number of positive items for each category, circle the box if the threshold was met or if ODD or CD is a concern)								
Retrospective Childhood symptom screen	IA	/9	HI	/9	ODD	/8	CD*	/15
<b>Current</b>								
Parent	IA	/9	HI	/9	ODD	/8	CD*	/15
Self	IA	/9	HI	/9	ODD	/8	CD*	/15
Teacher	IA	/9	HI	/9	ODD	/8	CD*	/15
Collateral	IA	/9	HI	/9	ODD	/8	CD*	/15
Other comorbid dx*								

\* Conduct disorder and other comorbid disorder only applies to the WSR

FOR ADULTS: The Adult ADHD Self Report Rating Scale (ASRS) can be used for current ADHD symptoms, part A being the screener section

<b>ADULT ADHD SELF REPORT RATING SCALE (ASRS)</b> (record the number of positive items for Part A and Part B, circle the box where threshold is made)			
Part A (Threshold > 4)	/6	Part B	/12

**STEP THREE: Administer the Weiss Functional Inventory Rating Scale (WFIRS)**

<b>WEISS FUNCTIONAL INVENTORY RATING SCALE (WFIRS)</b> (record the number of items rated 2 or 3, circle the boxes where you perceive a problem)														
<b>Parent</b>	Family	/10	School (learning)	/4	(behaviour)	/6	Life Skills	/10	Self	/3	Social	/7	Risk	/10
<b>Self</b>	Family	/8	Work	/11	School	/10	Life Skills	/12	Self	/5	Social	/9	Risk	/14

<b>OTHER SCALES</b>	

<b>Psychometric Evaluation – Done?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Requested		<b>Date(s) of Testing:</b>			
<b>Intelligence Tests Score:</b>		<input type="checkbox"/> marked below <input type="checkbox"/> borderline <input type="checkbox"/> low average <input type="checkbox"/> average <input type="checkbox"/> above average <input type="checkbox"/> marked above <input type="checkbox"/> superior			
<b>WISC or WAIS</b> (%ile or scaled score)	<b>Verbal Comprehension</b>	<b>Perceptual Reasoning</b>	<b>Working Memory</b>	<b>Processing Speed</b>	<b>Older IQ tests used %ile/IQ</b> Full Scale IQ Verbal IQ Performance IQ
<b>Achievement tests Score:</b> -2 (>2 yrs below) -1 (1-2 yrs below) 0 (grade level) +1 (1-2 yrs above) +2 (>2 yrs above)					
<b>Grade level:</b>	Reading	Spelling	Math	Writing	

<b>MENTAL STATUS EXAMINATION</b> (clinical observations of the interview)

### **SUMMARY OF FINDINGS**

(This allows a clinician reflect on the global collection of information in readiness for the diagnosis, feedback and treatment)

Item of Relevance	N/A	Does not indicate ADHD	Marginally indicates ADHD	Strongly indicates ADHD	Comments
Symptoms of ADHD in childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Current ADHD symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Collateral information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of diagnosed first degree relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Review of school report cards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Previous psychiatric assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychometric/psychological assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<b>N/A</b>	Suggesting an alternative explanation is better	ADHD is possible but other factors relevant	ADHD is still the best explanation of findings	<b>Comments</b>
In utero exposure to substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neonatal insult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infant temperament	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial stressors before 12					
Accidents and injuries (particularly head injury)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Major trauma before age 12 (e.g. abuse-physical, sexual, neglect)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance use history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other medical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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## DIAGNOSIS

**Note: This table helps the clinician understand how the DSM-IV-TR records axial information**

Axis I: Actual diagnosis and any learning disabilities

Axis II: Mental retardation, developmental delay and any personality disorders (traits if sub-threshold for an actual disorder)

Axis III: Any medical disorders or any past medical disorders that might be important to note

Axis IV: Severity of psychosocial stressors: Name the stressors and indicate their severity from Mild, Moderate, Severe

Axis V: Global Assessment of Functioning: This is a number given (from the table below) that helps to monitor functioning over time.  
This is a quick way of being able to record clinical progress.

Axis V	CGAS Anchor Points	Score
91-100	Superior functioning in all aspects of life; active, likeable, confident	
90-81	Good functioning in school, home, peers, transient everyday worries have mild reaction	
80-71	Slight impairment in school, home or peers, transient behaviour and emotional reaction	
70-61	Difficulty in an area of life but functioning well (mood change, sporadic anti-social act)	
60-51	Variable functioning and sporadic difficulties in several areas of life, apparent to others	
50-41	Moderate interference in functioning or severe impairment in school, home or peers	
40-31	Major impairment; unable to function in one area (suicide attempt, persistent aggression, marked withdrawal and isolation, severe mood or thought disturbance)	
30-21	Unable to function in life, severe impairment in communication and reality testing	
20-11	Needs supervision to be safe and for self-care, gross impairment in communication	
10-0	Needs 24 hour supervision for severe aggressive, self-destructive behaviour, affect, thought, reality testing, communication impairment.	

### Diagnosis following DSM:

Axis I: DSM Diagnoses

Axis II: Personality/Developmental delay

Axis III: Medical conditions

Axis IV: Stressors (mild, moderate, severe)

Axis V: Global Assessment of Functioning

### Important Lifestyle Issues:

## Treatment Plan

Patient Name: \_\_\_\_\_ MRN/File No.: \_\_\_\_\_

	N/A	To Do	Done	Referred to and comments/Details
<b>Psychoeducation</b>				
Patient Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parent Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Info to School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Handouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Medical</b>				
Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CV Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Baseline Ratings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lab Investigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Pharmacological Interventions</b>				
Review Medication Options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Non Pharmacological Interventions</b>				
Psychological Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Skills Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anger Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Addiction Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive Behaviour Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parent Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OT Referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Educational &amp; Vocational</b>				
Psychoeducational Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Special Education/Accommodations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vocational Assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Workplace Accommodations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Completion of Special Forms</b>				
CRA Tax Credits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Copy sent to: \_\_\_\_\_ Fax No: \_\_\_\_\_

## Weiss Symptom Record (WSR) Instructions

### Purpose

- To collect systematic information from the patient and other informants about various disorders, including learning, developmental and personality difficulties
- To serve as a cross check to assist clinicians in focusing their mental status, assuring that they do not miss relevant but unusual comorbidities, and in differentiating disorders which have significant symptom overlap
- This screener is not 'diagnostic'.

### Unique Characteristics

- Since this symptom record can be completed by any informant, it enables a rapid comparison of symptom profiles across settings
- Items scored as 'pretty much' or 'very much' are in shaded columns so that quick scanning of the screener enables rapid identification of problematic symptom groupings
- Items are translated into simple language for ease of use
- Item selection attempted to assure not only sensitivity to identification of comorbid disorders, but also selection of items that would assist in differentiating those symptoms that are specific to one disorder and assist in differentiating it from another overlapping problem
- The formulation of items on the Weiss Symptom Record was based on DSM-IV criteria.<sup>1</sup>

### Scoring

This is not a psychometrically validated instrument but a clinical record of the DSM-IV criteria for various disorders. The DSM-IV criteria for diagnosis for each disorder are listed in the column labelled 'Diagnosis'. Answers should be scored as follows: Not at all = 0, Somewhat = 1, Pretty Much = 2, Very Much = 3.

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<sup>1</sup> In the development of this screener DSM-IV diagnostic criteria were used with permission of the American Psychiatric Press.



Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## Weiss Symptom Record (WSR)

<i>Instructions to Informant: Check the box that best describes typical behavior</i> <i>Instructions to Physician: Symptoms rated 2 or 3 are positive and total count completed below</i>	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	# items scored 2 or 3 (DSM Criteria)
<b>ADHD COMBINED TYPE 314.01</b>						<b>≥6/9 IA &amp; HI</b>
<b>ATTENTION 314.00</b>						
Fails to give close attention to details, careless mistakes						
Difficulty sustaining attention in tasks or fun activities						
Does not seem to listen when spoken to directly						
Does not follow through on instructions and fails to finish work						
Difficult organizing tasks and activities						
Avoids tasks that require sustained mental effort (boring)						
Losing things						
Easily distracted						
Forgetful in daily activities						/9 (≥6/9)
<b>HYPERACTIVE/IMPULSIVE 314.01</b>						
Fidgety or squirms in seat						
Leaves seat when sitting is expected						
Feels restless						
Difficulty in doing fun things quietly						
Always on the go or acts as if "driven by a motor"						
Talks excessively						
Blurts answers before questions have been completed						
Difficulty awaiting turn						
Interrupting or intruding on others						/9 (≥6/9)
<b>OPPOSITIONAL DEFIANT DISORDER 313.81</b>						
Loses temper						
Argues with adults						
Actively defies or refuses to comply with requests or rules						
Deliberately annoys people						
Blames others for his or her mistakes or misbehaviour						
Touchy or easily annoyed by others						
Angry or resentful						
Spiteful or vindictive						/8 (≥4/8)

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>TIC DISORDERS 307.2</b>						<b>SEVERITY</b>
Repetitive involuntary movements (blinking, twitching)						
Repetitive involuntary noises (throat clearing, sniffing)						
<b>CONDUCT DISORDER 312.8</b>						
Bullies, threatens, or intimidates others						
Initiates physical fights						
Has used a weapon (bat, brick, bottle, knife, gun)						
Physically cruel to people						
Physically cruel to animals						
Stolen while confronting a victim						
Forced someone into sexual activity						
Fire setting with the intent of damage						
Deliberately destroyed others' property						
Broken into a house, building, or car						
Often lies to obtain goods or benefits or avoid obligations						
Stealing items of nontrivial value without confronting victim						
Stays out at night despite prohibitions						
Run away from home overnight at least twice						
Truant from school						/15(≥3/15)
<b>ANXIETY</b>						
Worries about health, loved ones, catastrophe						300.02
Unable to relax; nervous						300.81
Chronic unexplained aches and pains						300.30
Repetitive thoughts that make no sense						
Repetitive rituals						300.01
Sudden panic attacks with intense anxiety						300.23
Excessively shy						
Refusal to do things in front of others						309.21
Refusal to go to school, work or separate from others						300.29
Unreasonable fears that interfere with activities						312.39
Pulls out hair, eyebrows						
Nail biting, picking						
Refusal to talk in public, but talks at home						mutism
<b>DEPRESSION 296.2 (single) .3 (recurrent)</b>						
Has been feeling sad, unhappy or depressed		Yes	No			Must be present
No interest or pleasure in life		Yes	No			Must be present
Feels worthless						
Has decreased energy and less productive						
Hopeless and pessimistic about the future						
Excessive feelings of guilt or self blame						
Self-injurious or suicidal thoughts						

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>DEPRESSION (CONT'D)</b>						<b>SEVERITY</b>
Social withdrawal						
Weight loss or weight gain						
Change in sleep patterns						≥5/9>2wks
Agitated or sluggish, slowed down						
Decreased concentration or indecisiveness						
Past suicide attempts	#	Serious				
<b>MANIA 296.0(manic) .6(mixes) .5(depressed)</b>						
Distinct period of consistent elevated or irritable mood	Yes	No	Must be present			
Grandiose, sudden increase in self esteem						
Decreased need for sleep						
Racing thoughts						
Too talkative and speech seems pressured						
Sudden increase in goal directed activity, agitated						≥3 >1wk
High risk activities (spending money, promiscuity)						/3 (≥3)
<b>SOCIAL SKILLS 299</b>						
Makes poor eye contact or unusual body language						
Failure to make peer relationships						
Lack of spontaneous sharing of enjoyment						
Lacks reciprocity or sensitivity to emotional needs of others						
Language delay or lack of language communication						
Difficulty communicating, conversing with others						
Speaks in an odd, idiosyncratic or monotonous speech						
Lack of creative, imaginative play or social imitation						
Intensely fixated on one particular interest						
Rigid sticking to nonfunctional routines or rituals						
Preoccupied with objects and parts of objects						
Repetitive motor mannerisms (hand flapping, spinning)						
<b>PSYCHOSIS 295</b>						
Has disorganized, illogical thoughts						
Hears voices or sees things						
Conviction that others are against or will hurt them						
People can read their thoughts, or vice versa						
Belief that the television is talking specifically to them						
A fixed belief that is out of touch with reality						
Thought sequence does not make sense						

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>SUBSTANCE ABUSE</b>						<b>SEVERITY</b>
Excessive alcohol (> 2 drinks/day, > 4 drinks at once)						305
Smokes cigarettes						
Daily marijuana use						
Use of any other street drugs						
Abuse of prescription drugs						
<b>SLEEP DISORDERS 307.4</b>						
Agitated or sluggish, slowed down						
Has difficulty falling asleep						
Has difficulty staying asleep						
Has abnormal sleep patterns during the day						347
Unanticipated falling asleep during the day						307.4
Sleep walking						307.4
Has nightmares						307.45
Falls asleep late and sleeps in late						3.27
Sleep schedule changes from day to day						
Excessive snoring						
A feeling of restless legs while trying to sleep						
Observed to have sudden kicking while asleep						780.57
Observed to have difficulty breathing at night						
<b>ELIMINATION DISORDERS 307</b>						
Wets the bed at night						
Wets during the day						
Soils self						
<b>EATING DISORDERS 307</b>						
Vomits after meals or bingeing						
Underweight and refuses to eat						307.1
Distorted body image						
Picky eater						
High junk food diet						
<b>LEARNING DISABILITIES 315</b>						
Delayed expressive language						
Stuttering						
Problems articulating words						315
Below grade level in reading						315.1
Below grade level in math						315.2
Trouble with writing (messy, tiring, avoids writing)						
Variable performance in school						
Underachieves at school relative to potential						315.4

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
<b>DEVELOPMENTAL COORDINATION DISORDER</b>						
Difficulty with gross motor skills (i.e. gym, sports, biking)						
Clumsy						
Difficulty with fine motor (buttons, shoe laces, cutting)						
<b>PERSONALITY 301</b>						<b>SEVERITY</b>
Unstable interpersonal relationships						
Frantic efforts to avoid abandonment						
Recurrent suicidal ideation or attempts						
Intense anger						
Major mood swings						BPD 301.83
Impulsive self destructive or self injurious behavior						
Fragile identity or self image						
Chronic feelings of emptiness						
Transient stress related dissociation or paranoia						/9 (≥5/9)
Self centred or entitled						NPD 301.81
Deceitful, aggressive, or lack of remorse						ASP 301.7
<b>COMMENTS:</b>						

ADHD=attention deficit hyperactivity disorder; IA=inattentive subtype; HI=hyperactive impulsive subtype; BPD=borderline personality disorder; NPD=narcissistic personality disorder; ASP=antisocial personality disorder.

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## **ADHD Checklist Instructions**

### **Scoring Instructions**

The ADHD Checklist is a list of the nine DSM items of attention and the nine DSM items of hyperactivity/impulsivity. Attention and impulsive-hyperactive items are grouped together so that the clinician can easily differentiate with a glance which area is primarily impaired. The number of items rated pretty much (2) or very much (3) are an indication that these areas are clinically problematic. Add up the numbers of clinically significant items and determine whether the client has met the threshold which is stated in next to the section heading (e.g. Attention > 6/9). If physicians are suspect but are unsure of whether ADHD is a possibility, the Checklist can be completed in the waiting room prior to assessment.

### **Comparison to Other Scales**

The items are also almost identical to those of the SNAP-IV scale, with the exception that the statement "Often ..." and then rating frequency as sometimes, often or very often has been deleted. Items have also been made generic enough to be appropriate to all age groups and so that they can be completed by any informant and for the past or present. The correlation between the DSM-IV checklists is very high (>.8). Therefore, if a clinician wishes to use an alternative checklist, the rating of number of positive items can be entered into the assessment form in the same way, noting the checklist used.

### **If Only ADHD**

The items on the ADHD Checklist are identical with the attention, hyperactive, and oppositional items at the beginning of the Weiss Symptom Record. This is so that the WSR can be given at baseline, but if the primary disorder is ADHD, follow-up assessments can be done by just using the Checklist and allowing for comparison.

### **The Checklist Used by Other Informants**

The Checklist can also be completed to identify ADHD in adults in childhood, or completed by a collateral informant as well as the patient.



Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

## ADHD CHECKLIST

Retrospective assessment of childhood symptoms  Current symptoms   
 Current medication: \_\_\_\_\_

<i>SYMPTOMS: Check the appropriate box</i>	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	Diagnoses
<b>ATTENTION 314.00 (≥6/9)</b>	<b>SEVERITY</b>				<b>TOTAL</b>
Fails to give close attention to details, careless mistakes					
Difficulty sustaining attention in tasks or fun activities					
Does not seem to listen when spoken to directly					
Does not follow through on instructions and fails to finish work					
Difficulty organizing tasks and activities					
Avoids tasks that require sustained mental effort (boring)					
Losing things					
Easily distracted					_/9
Forgetful in daily activities					≥6/9
<b>HYPERACTIVE/IMPULSIVE 314.01 (≥6/9)</b>					
Fidgety or squirms in seat					
Leaves seat when sitting is expected					
Feels restless					
Difficulty in doing fun things quietly					
Always on the go or acts as if "driven by a motor"					
Talks excessively					
Blurts answers before questions have been completed					
Difficulty awaiting turn					≥6/9
Interrupting or intruding on others					_/9
<b>OPPOSITIONAL DEFIANT DISORDER 313.81 (&gt;4/8)</b>					
Loses temper					
Argues with adults					
Actively defies or refuses to comply with requests or rules					
Deliberately annoys people					
Blames others for his or her mistakes or misbehavior					
Touchy or easily annoyed by others					
Angry or resentful					≥4/8
Spiteful or vindictive					_/8
<b>COMMENTS</b>					

## SNAP-IV 26 RATING SCALE: SCORING INSTRUCTIONS

The SNAP-IV is a revision of the Swanson, Nolan and Pelham (SNAP) questionnaire (Swanson et al. 1983). The items from the DSM-IV criteria for Attention Deficit Hyperactivity Disorder (ADHD) are included for the two following subsets of symptoms: inattention (items 1 to 9) and hyperactivity/impulsivity (items 10 to 18). The scale also includes the DMS-IV criteria for Oppositional Defiant Disorder (items 19 to 26) since this is often present in children with ADHD.

The SNAP-IV is based on a 0 to 3 rating scale: Not at all = 0, Just a little = 1, Often = 2, and Very often = 3. Sub scale scores on the SNAP-IV are calculated by summing the scores on the subset and dividing by the number of items in the subset. The score for any subset is expressed as the Average Rating-Per-Item, as shown for ratings on the ADHD-Inattentive (ADHD-I) subset:

	Not at all (0)	Just a little (1)	Often (2)	Very often (3)	Score
1. Makes careless mistakes			*		2
2. Difficulty sustaining attention				*	3
3. Does not listen				*	3
4. Fails to finish work			*		2
5. Disorganized		*			1
6. Can't concentrate				*	3
7. Loses things		*			1
8. Easily distracted				*	3
9. Forgetful	*				0

Total ADHD-Inattention = 18

Average =  $18/9 = 2.0$

ADHD-Inattention	ADHD-Hyperactivity/Impusivity	Oppositional Defiant Disorder
#1	#10	#19
#2	#11	#20
#3	#12	#21
#4	#13	#22
#5	#14	#23
#6	#15	#24
#7	#16	#25
#8	#17	#26
#9	#18	
<b>Total</b>	<b>Total</b>	<b>Total</b>
<b>Average</b>	<b>Average</b>	<b>Average</b>



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Physician Name: \_\_\_\_\_

MRN/File No: \_\_\_\_\_

Date: \_\_\_\_\_

## SNAP-IV 26 – Teacher and Parent Rating Scale

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Grade: \_\_\_\_\_ Ethnicity:  African-American  Asian  Caucasian  Hispanic Other: \_\_\_\_\_

Completed by: \_\_\_\_\_ Type of Class: \_\_\_\_\_ Class size: \_\_\_\_\_

<i>For each item, check the column which best describes this child:</i>	Not At All	Just A Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions				
11. Often fidgets with hands or feet or squirms in seat				
12. Often leaves seat in classroom or in other situations in which remaining seated is expected				
13. Often runs about or climbs excessively in situations in which it is inappropriate				
14. Often has difficulty playing or engaging in leisure activities quietly				
15. Often is "on the go" or often acts as if "driven by a motor"				
16. Often talks excessively				
17. Often blurts out answers before questions have been completed				
18. Often has difficulty awaiting turn				
19. Often loses temper				
20. Often argues with adults				
21. Often actively defies or refuses adult requests or rules				
22. Often deliberately does things that annoy other people				
23. Often blames others for his or her mistakes or misbehavior				
24. Often touchy or easily annoyed by others				
25. Often is angry and resentful				
26. Often is spiteful or vindictive				

## ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST INSTRUCTIONS

### Description:

The Symptom Checklist is an instrument consisting of the 18 DSM-IV-TR criteria. Six of the 18 questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS-V1.1 screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining 12 questions.

### Instructions:

#### Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.
2. Score Part A. If four or more marks appear under Often/Very Often then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.
3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing under Often/Very Often. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the 12 questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

#### Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.
2. Consider work/school, social and family settings.
3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

#### History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

#### References:

1. Schweitzer JB et al. *Med Clin North Am.* 2001;85(3),10-11:757-777.
  2. Barkley RA. *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment.* 2nd ed. 1998.
  3. Biederman J, et al. *Am J Psychiatry.* 1993;150:1792-1798.
  4. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. 2000:85-93.
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Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

<i>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 your appointment.</i>	Never	Rarely	Sometimes	Often	Very often
<b>PART A</b>					
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?					
<b>PART B</b>					
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?					
12. How often do you leave your seat in meetings or in other situations in which you are expected to stay 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 it 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?					

## WEISS FUNCTIONAL IMPAIRMENT RATING SCALE (WFIRS) INSTRUCTIONS

### Purpose

- ADHD symptoms and actual impairment overlap but are distinct concepts. It is important to measure both since some patients are highly symptomatic but not impaired or vice versa
- This scale contains those items that are most likely to represent the patient's target of treatment. Therefore, the use of the scale before and after treatment can allow the clinician to determine not only if the ADHD has improved, but if the patient's functional difficulties are also better.
- This instrument has been translated into 18 languages. It has been used in many studies and is psychometrically validated. This is the only measure of functional impairment that looks at specific domains and has been validated in the ADHD population.

### Design and Validation Information

*Scoring* The instrument uses a Likert scale such that any item rating 2 or 3 is clinically impaired. The scale can be scored by looking at the total score or by creating a mean score for the total score/number items for each domain, omitting those rated not applicable. For clinical purposes, when defining impairment for DSM-IV, clinicians can consider that any domain with at least two items scored 2, one item scored 3 or a mean score  $>1.5$  is impaired.

*Validation* The scale has been psychometrically validated with an internal consistency  $>.8$  for each domain and for the scale as a whole. It has moderate convergent validity (0.6) with other measures of functioning (i.e. Columbia Impairment Scale and the Global Assessment of Functioning (GAF)). It has moderate discriminating validity (0.4) from symptoms pre-treatment (i.e. ADHD-Rating Scale) and quality of life (CHIP). The domains have been confirmed by factor analysis, although the domain of school functioning separates into learning and behaviour. The scale is highly sensitive to change with treatment and, in particular, significantly correlated to change in ADHD symptoms (40% change) and overall psychopathology. Each anchor point on the Likert scale represents approximately one standard deviation (SD). A total score change of 13 would be considered a significant improvement or about half a SD. The change obtained in treatment is typically one full SD. The mean score for risky behaviour in children is 0.5 but increases with age. For adolescents the mean score is 1.

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### Margaret D Weiss MD PhD FRCP(C)

Clinic Head, Provincial ADHD Program  
Clinical Professor, University of British Columbia  
Box 178, 4500 Oak St.  
Department of Psychiatry  
Children's and Women's Health Centre, Room P-229  
Telephone: 604 875 2738 Fax: 604 875 2099  
Email: mweiss@cw.bc.ca



Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – SELF REPORT (WFIRS-S)

Name: \_\_\_\_\_ Date:      DD MM YY

Date of birth:      DD MM YY Sex:  Male  Female

Work:  Full time  Part time  Other \_\_\_\_\_

School:  Full time  Part time

*Circle the number for the rating that best describes how your emotional or behavioural problems have affected each item in the last month.*

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>A</b>	<b>FAMILY</b>					
1	Having problems with family	0	1	2	3	n/a
2	Having problems with spouse/partner	0	1	2	3	n/a
3	Relying on others to do things for you	0	1	2	3	n/a
4	Causing fighting in the family	0	1	2	3	n/a
5	Makes it hard for the family to have fun together	0	1	2	3	n/a
6	Problems taking care of your family	0	1	2	3	n/a
7	Problems balancing your needs against those of your family	0	1	2	3	n/
8	Problems losing control with family	0	1	2	3	n/a
<b>B</b>	<b>WORK</b>					
1	Problems performing required duties	0	1	2	3	n/a
2	Problems with getting your work done efficiently	0	1	2	3	n/a
3	Problems with your supervisor	0	1	2	3	n/a
4	Problems keeping a job	0	1	2	3	n/a
5	Getting fired from work	0	1	2	3	n/a
6	Problems working in a team	0	1	2	3	n/a
7	Problems with your attendance	0	1	2	3	n/a
8	Problems with being late	0	1	2	3	n/a
9	Problems taking on new tasks	0	1	2	3	n/a
10	Problems working to your potential	0	1	2	3	n/a
11	Poor performance evaluations	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>C</b>	<b>SCHOOL</b>					
1	Problems taking notes	0	1	2	3	n/a
2	Problems completing assignments	0	1	2	3	n/a
3	Problems getting your work done efficiently	0	1	2	3	n/a
4	Problems with teachers	0	1	2	3	n/a
5	Problems with school administrators	0	1	2	3	n/a
6	Problems meeting minimum requirements to stay in school	0	1	2	3	n/a
7	Problems with attendance	0	1	2	3	n/a
8	Problems with being late	0	1	2	3	n/a
9	Problems with working to your potential	0	1	2	3	n/a
10	Problems with inconsistent grades	0	1	2	3	n/a
<b>D</b>	<b>LIFE SKILLS</b>					
1	Excessive or inappropriate use of internet, video games or TV	0	1	2	3	n/a
2	Problems keeping an acceptable appearance	0	1	2	3	n/a
3	Problems getting ready to leave the house	0	1	2	3	n/a
4	Problems getting to bed	0	1	2	3	n/a
5	Problems with nutrition	0	1	2	3	n/a
6	Problems with sex	0	1	2	3	n/a
7	Problems with sleeping	0	1	2	3	n/a
8	Getting hurt or injured	0	1	2	3	n/a
9	Avoiding exercise	0	1	2	3	n/a
10	Problems keeping regular appointments with doctor/dentist	0	1	2	3	n/a
11	Problems keeping up with household chores	0	1	2	3	n/a
12	Problems managing money	0	1	2	3	n/a
<b>E</b>	<b>SELF-CONCEPT</b>					
1	Feeling bad about yourself	0	1	2	3	n/a
2	Feeling frustrated with yourself	0	1	2	3	n/a
3	Feeling discouraged	0	1	2	3	n/a
4	Not feeling happy with your life	0	1	2	3	n/a
5	Feeling incompetent	0	1	2	3	n/a
<b>F</b>	<b>SOCIAL</b>					
1	Getting into arguments	0	1	2	3	n/a
2	Trouble cooperating	0	1	2	3	n/a
3	Trouble getting along with people	0	1	2	3	n/a
4	Problems having fun with other people	0	1	2	3	n/a
5	Problems participating in hobbies	0	1	2	3	n/a
6	Problems making friends	0	1	2	3	n/a
7	Problems keeping friends	0	1	2	3	n/a
8	Saying inappropriate things	0	1	2	3	n/a
9	Complaints from neighbours	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>G</b>	<b>RISK</b>					
1	Aggressive driving	0	1	2	3	n/a
2	Doing other things while driving	0	1	2	3	n/a
3	Road rage	0	1	2	3	n/a
4	Breaking or damaging things	0	1	2	3	n/a
5	Doing things that are illegal	0	1	2	3	n/a
6	Being involved with the police	0	1	2	3	n/a
7	Smoking cigarettes	0	1	2	3	n/a
8	Smoking marijuana	0	1	2	3	n/a
9	Drinking alcohol	0	1	2	3	n/a
10	Taking "street" drugs	0	1	2	3	n/a
11	Sex without protection (birth control, condom)	0	1	2	3	n/a
12	Sexually inappropriate behaviour	0	1	2	3	n/a
13	Being physically aggressive	0	1	2	3	n/a
14	Being verbally aggressive	0	1	2	3	n/a

**SCORING:**

1. Number of items scored 2 or 3  
*or*
2. Total score  
*or*
3. Mean score

<b>DO NOT WRITE IN THIS AREA</b>	
A. Family	<input type="text"/>
B. Work	<input type="text"/>
C. School	<input type="text"/>
D. Life skills	<input type="text"/>
E. Self-concept	<input type="text"/>
F. Social	<input type="text"/>
G. Risk	<input type="text"/>
<b>Total</b>	<input type="text"/>

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Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

## WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – PARENT REPORT (WFIRS-P)

Your name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

*Circle the number for the rating that best describes how your child's emotional or behavioural problems have affected each item in the last month.*

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
<b>A</b>	<b>FAMILY</b>					
1	Having problems with brothers & sisters	0	1	2	3	n/a
2	Causing problems between parents	0	1	2	3	n/a
3	Takes time away from family members' work or activities	0	1	2	3	n/a
4	Causing fighting in the family	0	1	2	3	n/a
5	Isolating the family from friends and social activities	0	1	2	3	n/a
6	Makes it hard for the family to have fun together	0	1	2	3	n/a
7	Makes parenting difficult	0	1	2	3	n/a
8	Makes it hard to give fair attention to all family members	0	1	2	3	n/a
9	Provokes others to hit or scream at him/her	0	1	2	3	n/a
10	Costs the family more money	0	1	2	3	n/a
<b>B</b>	<b>SCHOOL</b>					
	<b>Learning</b>					
1	Makes it difficult to keep up with schoolwork	0	1	2	3	n/a
2	Needs extra help at school	0	1	2	3	n/a
3	Needs tutoring	0	1	2	3	n/a
4	Receives grades that are not as good as his/her ability	0	1	2	3	n/a
	<b>Behaviour</b>					
1	Causes problems for the teacher in the classroom	0	1	2	3	n/a
2	Receives "time-out" or removal from the classroom	0	1	2	3	n/a
3	Having problems in the school yard	0	1	2	3	n/a
4	Receives detentions (during or after school)	0	1	2	3	n/a
5	Suspended or expelled from school	0	1	2	3	n/a
6	Misses classes or is late for school	0	1	2	3	n/a
<b>C</b>	<b>LIFE SKILLS</b>					
1	Excessive use of TV, computer, or video games	0	1	2	3	n/a
2	Keeping clean, brushing teeth, brushing hair, bathing, etc.	0	1	2	3	n/a
3	Problems getting ready for school	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
4	Problems getting ready for bed	0	1	2	3	n/a
5	Problems with eating (picky eater, junk food)	0	1	2	3	n/a
6	Problems with sleeping	0	1	2	3	n/a
7	Gets hurt or injured	0	1	2	3	n/a
8	Avoids exercise	0	1	2	3	n/a
9	Needs more medical care	0	1	2	3	n/a
10	Has trouble taking medication, getting needles or visiting the doctor/dentist	0	1	2	3	n/a
<b>D</b>	<b>CHILD'S SELF-CONCEPT</b>					
1	My child feels bad about himself/herself	0	1	2	3	n/a
2	My child does not have enough fun	0	1	2	3	n/a
3	My child is not happy with his/her life	0	1	2	3	n/a
<b>E</b>	<b>SOCIAL ACTIVITIES</b>					
1	Being teased or bullied by other children	0	1	2	3	n/a
2	Teases or bullies other children	0	1	2	3	n/a
3	Problems getting along with other children	0	1	2	3	n/a
4	Problems participating in after-school activities (sports, music, clubs)	0	1	2	3	n/a
5	Problems making new friends	0	1	2	3	n/a
6	Problems keeping friends	0	1	2	3	n/a
7	Difficulty with parties (not invited, avoids them, misbehaves)	0	1	2	3	n/a
<b>F</b>	<b>RISKY ACTIVITIES</b>					
1	Easily led by other children (peer pressure)	0	1	2	3	n/a
2	Breaking or damaging things	0	1	2	3	n/a
3	Doing things that are illegal	0	1	2	3	n/a
4	Being involved with the police	0	1	2	3	n/a
5	Smoking cigarettes	0	1	2	3	n/a
6	Taking illegal drugs	0	1	2	3	n/a
7	Doing dangerous things	0	1	2	3	n/a
8	Causes injury to others	0	1	2	3	n/a
9	Says mean or inappropriate things	0	1	2	3	n/a
10	Sexually inappropriate behaviour	0	1	2	3	n/a

**SCORING:**

1. Number of items scored 2 or 3  
*or*
2. Total score  
*or*
3. Mean score

**DO NOT WRITE IN THIS AREA**

A. Family	
B. School Learning Behaviour	
C. Life skills	
D. Child's self-concept	
E. Social activities	
F. Risky activities	
<b>Total</b>	

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Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

### CADDRA Teacher Assessment Form

*Adapted from Dr Rosemary Tannock's Teacher Telephone Interview.  
Reprinted for clinical use only with permission from the BC Provincial ADHD Program.*

Student's Name:	Age:	Sex:
School:	Grade:	

Educator completing this form: \_\_\_\_\_ Date completed: \_\_\_\_\_  
 How long have you known the student? \_\_\_\_\_ Time spent each day with student: \_\_\_\_\_  
 Student's Placement: \_\_\_\_\_ Special Ed:  Yes  No Hrs per week: \_\_\_\_\_  
 Student's Educational Designation: \_\_\_\_\_  None  
 Does this student have an educational plan?:  Yes  No

ACADEMIC PERFORMANCE	Well Below Grade Level	Somewhat Below Grade Level	At Grade Level	Somewhat Above Grade Level	Well Above Grade Level	n/a
READING						
a) Decoding						
b) Comprehension						
c) Fluency						
WRITING						
d) Handwriting						
e) Spelling						
f) Written syntax (sentence level)						
g) Written composition (text level)						
MATHEMATICS						
h) Computation (accuracy)						
i) Computation (fluency)						
j) Applied mathematical reasoning						
CLASSROOM PERFORMANCE	Well Below Average	Below Average	Average	Above Average	Well Above Average	n/a
Following directions/instructions						
Organizational skills						
Assignment completion						
Peer relationships						
Classroom Behaviour						

# CADDRA Teacher Assessment Form

**Strengths:** What are this student's strengths? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Education plan:** If this student has an education plan, what are the recommendations? Do they work? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Accommodations:** What accommodations are in place? Are they effective? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Class Instructions:** How well does this student handle large-group instruction? Does s/he follow instructions well? Can s/he wait for a turn to respond? Would s/he stand out from same-sex peers? In what way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Individual seat work:** How well does this student self-regulate attention and behaviour during assignments to be completed as individual seat work? Is the work generally completed? Would s/he stand out from same-sex peers? In what way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Transitions:** How does this student handle transitions such as going in and out for recess, changing classes or changing activities? Does s/he follow routines well? What amount of supervision or reminders does s/he need? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Impact on peer relations:** How does this student get along with others? Does this student have friends that seek him/her out? Does s/he initiate play successfully? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Conflict and Aggression:** – Is s/he often in conflict with adults or peers? How does s/he resolve arguments? Is the student verbally or physically aggressive? Is s/he the target of verbal or physical aggression by peers? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Academic Abilities:** We would like to know about this student's general abilities and academic skills. Does this student appear to learn at a similar rate to others? Does this student appear to have specific weaknesses in learning? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Self-help skills,** independence, problem solving, activities of daily living: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Motor Skills (gross/fine):** Does this student have problems with gym, sports, writing? If so, please describe.

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**Written output:** Does this student have problems putting ideas down in writing? If so, please describe.

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**Primary Areas of concern:** What are your major areas of concern/worry for this student? How long has this/these been a concern for you? \_\_\_\_\_

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**Impact on student:** To what extent are these difficulties for the student upsetting or distressing to the student him/herself, to you and/or the other students? \_\_\_\_\_

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**Impact on the class:** Does this student make it difficult for you to teach the class? \_\_\_\_\_

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**Medications:** If this student is on medication, is there anything you would like to highlight about the differences when s/he is on medication compared to off? \_\_\_\_\_

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**Parent involvement:** What has been the involvement of the parent(s)? \_\_\_\_\_

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Are the problems with attention and/or hyperactivity interfering with the student's learning? Peer relationships? \_\_\_\_\_

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Has the student had any particular problems with homework or handing in assignments? \_\_\_\_\_

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Is there anything else you would like us to know? If you feel the need to contact the student's clinician during this assessment please feel free to do so. \_\_\_\_\_

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Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

## CADDRA CLINICIAN ADHD BASELINE/FOLLOW-UP FORM

Patient Name: _____		Date of Birth: _____		Date seen: _____		
Other person present during interview: _____						
Clinician:			Other therapist(s) involved:			
Current medication(s):		Dose & schedule	Therapeutic Effects	Side Effects		
Adherence to treatment (took medications as directed)						
<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL (missed doses, did not take all medication) <input type="checkbox"/> NONE (Discontinued medication for at least a week)						
Developments since last appointment:						
Height:	Weight:	BP:	Pulse:	Observations:		
Opinion						
Axis I	<input type="checkbox"/> ADHD, Combined	<input type="checkbox"/> Oppositional Defiant	<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Learning Disorder	
	<input type="checkbox"/> ADHD, Inattentive	<input type="checkbox"/> Conduct Disorder	<input type="checkbox"/> Tic Disorder	<input type="checkbox"/> Language Disorder	<input type="checkbox"/> Other	
Axis II	<input type="checkbox"/> Personality Disorder <input type="checkbox"/> Mental retardation					
Axis III (physical abnormalities)						
Axis IV	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme	Axis V (Clinical Global Assessment of Functioning 1-100)	
Impairment Severity	<input type="checkbox"/> Borderline	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
<input type="checkbox"/> Very much improved	<input type="checkbox"/> Much improved	<input type="checkbox"/> Minimally improved	<input type="checkbox"/> No change	<input type="checkbox"/> Minimally worse	<input type="checkbox"/> Much worse	<input type="checkbox"/> Very much worse
Treatment Plan						
Medication: <input type="checkbox"/> No change <input type="checkbox"/> Decrease <input type="checkbox"/> Increase <input type="checkbox"/> Switch						
Psychological/Other:						
School/work:						
Follow-up plan:						
Signature:			Date:			
<input type="checkbox"/> Copy to be sent to:						



Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

## CADDRA PATIENT ADHD MEDICATION FORM

Please complete and bring to your next appointment

Patient name: \_\_\_\_\_ Date form is completed: \_\_\_\_\_

Person completing this form (if not the patient): \_\_\_\_\_  Mother  Father  Other

Medication usage since (decided with doctor): \_\_\_\_\_  
 \_\_\_\_\_ (date)

- Medication not started yet
- Takes medication regularly, as prescribed
- Forgets/skips doses occasionally
- Takes medication irregularly
- Medication stopped

### Current Medication List:

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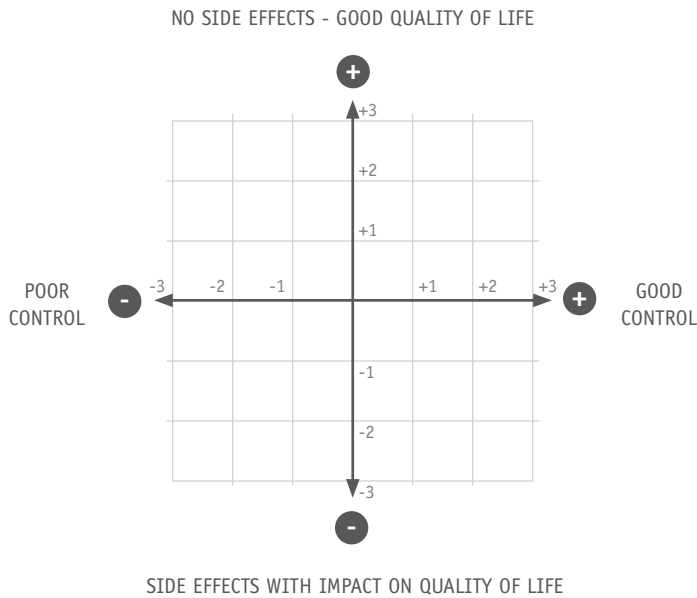
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### Instructions to use the quadrant below:

- Place a mark on the horizontal black line indicating the level of current symptom control between -3 and +3.
- Place a mark on the vertical black line indicating current side effect levels, between -3 to +3
- Draw an X where lines from the marks made on each line would meet to show current patient status



### COMMENTS:

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### What changes have occurred since medication started?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Not applicable: no medication taken | <input type="checkbox"/> No change            | <input type="checkbox"/> Marked Improvement |
| <input type="checkbox"/> Small deterioration                 | <input type="checkbox"/> Improvement          | <input type="checkbox"/> Deterioration      |
| <input type="checkbox"/> Small improvement                   | <input type="checkbox"/> Marked deterioration |   |

Please indicate below the frequency of any side effects experienced since the last medical appointment (mark with an X). Please contact your physician if side effects are significant.

SIDE EFFECT	FREQUENCY				Comments
	Not at all	Sometimes	Often	All the time	
Headache					
Dryness of the skin					
Dryness of the eyes					
Dryness of the mouth					
Thirst					
Sore throat					
Dizziness					
Nausea					
Stomach aches					
Vomiting					
Sweating					
Appetite reduction					
Weight loss					
Weight gain					
Diarrhea					
Frequent urination					
Tics					
Sleep difficulties					
Mood instability					
Irritability					
Agitation/excitability					
Sadness					
Heart palpitations					
Increased blood pressure					
Sexual dysfunction					
Feeling worse or different when the medication wears off (rebound)					
<b>Other:</b>					

**Things to discuss at the next medical appointment:**

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## **CADDRA ADHD ASSESSMENT TOOLKIT (CAAT) HANDOUTS**

### **Handouts**

CADDRA ADHD Information and Resources .....	125
CADDRA Child Assessment Instructions .....	129
CADDRA Adolescent Assessment Instructions .....	130
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## **CADDRA ADHD INFORMATION AND RESOURCES**

*Adapted for CADDRA with permission, by Dr Annick Vincent, Centre médical L'Hôtrière, Clinique FOCUS, Québec.*

### **Description**

Attention Deficit Hyperactivity Disorder is a neurological condition that leads to difficulty regulating attention, controlling excessive physical activity, and impulsivity.

ADHD affects about one in twenty children and follow-up studies have shown that symptoms persist into adulthood for more than half of these. A recent U.S. study estimated that 4% of adults have ADHD. Adults with ADHD suffer from distractibility and mental restlessness, disorganization and procrastination, leading to difficulties beginning and completing tasks and with time management and impulsivity. These symptoms can be as impairing at work as in a person's private life. At times, people suffering from ADHD also have difficulty regulating their emotional responses. They are referred to as being "thin-skinned" or "hypersensitive" and as having a "short fuse". Often, these individuals deal with their physical restlessness by channelling it into work or sports activities. Some will "self-medicate" by taking stimulants such as caffeine or nicotine or illicit drugs such as cannabis or cocaine.

Due to the impact of their symptoms, many people with ADHD also suffer from poor self esteem and a chronic sense of under-achievement.

### **Causes**

While we do not know the exact cause of ADHD, science shows that in most cases ADHD has been inherited. Occasionally, ADHD can also be caused by a traumatic brain injury, lack of oxygen, neurological damage or infection, prematurity, or prenatal exposure to substances such as alcohol or nicotine.

ADHD is a neurodevelopmental condition. It is not caused by poor parenting or by psychological stress, although raising an ADHD child can be both challenging and stressful. However, environment can impact the expression and progression of ADHD. When ADHD is treated properly, physicians are usually able to decrease the symptoms and improve functioning. Physicians can also recommend adaptations at school, college or in the workplace and empower the patient and/or parents so that they do not feel alone.

Scientific research has revealed some dysfunction in particular information neurotransmitters, such as dopamine and noradrenaline. These chemicals help to carry signals across synapses in the brain. Studies of brain function in persons with ADHD have revealed an impairment of the regions responsible for controlling or inhibiting certain behaviours, such as initiating tasks, being able to stop unwanted behaviour, understanding consequences, holding information in the mind and being able to plan for the future. In ADHD, the information transmission network appears to be somewhat impaired - as if the "go" and "stop" signals are delayed.

## **Why consult a doctor?**

Patients seek medical attention for many different reasons. If a child or adolescent is experiencing difficulties regulating his/her attention or is demonstrating hyperactivity in the classroom, educators may report to the parents on what they are seeing and recommend assessment. Increased media and online information on ADHD has resulted in a rise in self-referral among adults. Once a child is diagnosed, parents may seek out an assessment if they recognize ADHD symptoms in themselves. Whatever way a patient comes to a physician, the first task for the individual will be to explain his/her concerns and problems.

## **Assessment**

Just because a person has difficulty concentrating, or can not sit still, this does not mean that he/she has ADHD. The only way to establish this is through a diagnostic assessment. This takes the form of an interview with the patient or his/her parents where symptoms and impairments are discussed. ADHD is only diagnosed if the symptoms are impairing. If this is the case, the doctor, patient and/or family must decide whether treatment is needed and, if so, what kind. It is essential to also look at any associated problems and conditions in order to establish an effective and personalized treatment plan.

Psychological evaluations can assist in assessing whether any learning and/or social impairments exist. This will help to exclude any other possible diagnoses. However, psychological tests and rating scales alone cannot be used to make a diagnosis without a full medical evaluation. While ADHD is a medical diagnosis, there are no laboratory tests to determine if it is present.

## **Diagnosis**

ADHD treatment begins with the confirmation of the diagnosis. This is followed by an explanation on how the symptoms, which the child, adolescent or adult has been exhibiting, can be explained by the diagnosis. A diagnosis can be bittersweet and acceptance may take time. On one hand, a patient and/or parent is often relieved to know what the problem is and, in the case of parents, that poor parenting is not the cause. However receiving a diagnosis of a chronic condition is generally not perceived as good news.

## **Treatment**

While medication can dramatically improve symptoms, medication alone is never enough. In the case of a child or adolescent, the parents, child and school must work together to understand that a diagnosis is not “an excuse” but will require the implementation of learning strategies and new parenting methods. Work place accommodations may be required for adults. Access to resources, such as parent training or (for adults) cognitive behavioural therapy, is slowly becoming more available through the public health care system.

When a person continues to be incapacitated by their ADHD symptoms, medication may be helpful and a medication trial should be initiated. A trial of more than one medication and more than one dose may be required in order to find the optimal one. Medication must be evaluated at least twice a year, so no medication decision is forever.

Medication for ADHD can work somewhat like glasses for those with vision problems. It can help improve the brain’s ability to focus. It improves the flow of signals along synapses allowing better information transmission.

There are many different types of medication available. The most common are stimulants of which there are two types, methylphenidate and amphetamines. Each of these medications comes in short-, intermediate- and long-acting forms. The most common side effects of stimulants are decreased appetite, trouble sleeping and becoming quiet, sad or irritable when the medication wears off.

The second type of medication is called a “nonstimulant”. It works by a completely different mechanism. This medication becomes effective once a certain level is reached in the blood stream. If, after a month of taking the medication at the full dose level, there is a 25% improvement in symptoms, the patient will probably respond well. However, the medication will continue to improve symptom control for up to four months. Your doctor will start all medication at a low dose and slowly increase the dose until maximum symptom control is experienced with the minimum amount of side effects. At this time another evaluation should be carried out to decide if added interventions are required.

Any co-existing mood or anxiety disorder must be taken into account in a treatment plan. Stimulant medication can sometimes aggravate certain anxiety disorders. Several antidepressants act on noradrenaline or dopamine and can also assist with ADHD symptoms but clinical studies have not yet studied the effects of these products specifically on ADHD. When ADHD and depression or anxiety disorder exist together, the doctor may begin treatment with a medication used to treat these disorders before implementing an ADHD-specific treatment. Ideally, the final treatment or treatments will consist of a single medication or a mix of medications that will provide the utmost symptom control with the least number of adverse effects.

ADHD medications have an effective rate of 50% to 70%. Although generally well tolerated, all drugs can produce side effects. Discuss any treatment being considered beforehand with your doctor and pharmacist. Although your doctor will provide you with research-based information on treatment options, the only way to determine the impact on your child or yourself is to go through a supervised medication trial.

Additional information on ADHD medications is available on the CADDAC website ([www.caddac.ca](http://www.caddac.ca)). Select the “ADHD Subjects” tab along the top menu and scroll down to “Treatments” for information on children and adolescent or adult medications.

## **List of Resources on ADHD**

### **Support Groups**

Look for support groups in your area on the CADDAC website ([www.caddac.ca](http://www.caddac.ca)) under Resources.

### **Websites**

Canadian ADHD Resource Alliance (CADDRA) – [www.caddra.ca](http://www.caddra.ca)

Centre for ADD/ADHD Advocacy, Canada (CADDAC) – [www.caddac.ca](http://www.caddac.ca)

Attention Deficit Disorder Association (ADDA) - [www.add.org](http://www.add.org)

Answers to your questions about ADHD (Patricia O. Quinn, MD and Kathleen Nadeau, PhD) - [www.ADDvance.com](http://www.ADDvance.com)

Online catalogue of ADHD resources – [www.addwarehouse.com](http://www.addwarehouse.com)

Quebec-based Dr Annick Vincent's ADHD website - [www.attentiondeficit-info.com](http://www.attentiondeficit-info.com)

Children and Adults with Attention Deficit Hyperactivity Disorder – [www.chadd.org](http://www.chadd.org)

Connecting doctors, parents and teachers – [www.myadhd.com](http://www.myadhd.com)

Online planner - [www.skoach.com](http://www.skoach.com)

Totally ADD – [www.totallyadd.com](http://www.totallyadd.com)

### **Canadian DVDs on ADHD**

*Portrait of Attention Deficit / Hyperactivity Disorder* Dr. Annick Vincent and the educational department of ISMQ (2007); Quebec City (418-663-5146)

*ADHD Across The Lifespan*, Timothy S. Bilkey, Ontario; [www.bilkeyadhdclinic.com](http://www.bilkeyadhdclinic.com)

*Various DVDs for patients, parents and educators* CADDAC, Toronto: [www.caddac.ca](http://www.caddac.ca)

## Books

- Adler, L. and Florence, M. (2006) *Scattered Minds: Hope and Help for Adults with ADHD*, New York: Putnam.
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Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

## CADDRA Child Assessment Instructions

Name of the child: \_\_\_\_\_ Date: \_\_\_\_\_

Parent(s): \_\_\_\_\_  
 \_\_\_\_\_

Time period for which the form was filled out: \_\_\_\_\_

If the child was on medication when this was completed, what medication was s/he on? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Your child is presently being evaluated for Attention Deficit Hyperactivity Disorder. Your doctor will require you to complete the following questionnaires as part of this process. (All these documents can be downloaded and printed from the Guidelines section on the CADDRA website: [www.caddra.ca](http://www.caddra.ca)). Your input is very important, but please do not worry about answering the questions incorrectly. There are no right or wrong answers. You will be asked questions about how your child functions in a variety of different ways. If you are unsure of an answer, go with your first instinct. Individual questions are less important than the scale as a whole. If the child is living in two households, each household should complete these forms.

### Questionnaires

- Weiss Symptom Record: To be completed by both parents
- WFIRS-P: To be completed by parents
- ADHD Checklist
- CADDRA Teacher Assessment Form
- SNAP-IV 26

If your child is on medication, it would be helpful if you could fill in the forms twice in order to assess the child on and off medication. Please fill in the forms in two different colours to demonstrate the differences.

If your child has already started using ADHD medication, please also complete the CADDRA Patient ADHD Medication Form. If not, please keep this form on hand for possible future use.

- CADDRA Patient ADHD Medication Form

### Information Sheets

Please read the information provided and note any questions that you might wish to discuss at your next appointment.

- CADDRA ADHD Information and Resources

### Points to discuss at the next medical appointment:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Physician Name: \_\_\_\_\_

MRN/File No: \_\_\_\_\_

Date: \_\_\_\_\_

## CADDRA Adolescent Assessment Instructions

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent(s): \_\_\_\_\_  
\_\_\_\_\_

Time period for which the form was filled out: \_\_\_\_\_

If you were on medication when this was completed, what medication were you on? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are presently being evaluated for Attention Deficit Hyperactivity Disorder. During this process, your doctor will require you and those who know you best (your parents and a teacher) to complete some questionnaires. (These questionnaires can also be downloaded and printed from the Guidelines section on the CADDRA website: [www.caddra.ca](http://www.caddra.ca)). Your input is very important, but please do not worry about answering the questions incorrectly. There are no right or wrong answers. You will be asked questions about how you function in a variety of different ways. If you are unsure of an answer, go with your first instinct. Individual questions are less important than the scale as a whole. If you are living in two households, each household should complete these forms.

### Questionnaires

- Weiss Symptom Record: To be completed by both parents, (you can also try to complete it by yourself if you wish).
- WFIRS-S: To be completed by yourself
- WFIRS-P: To be completed by both parents
- ADHD Checklist
- SNAP-IV 26

If you are taking medication, you can also complete the forms both on medication and off medication. In this case, it would be helpful if you use two different colours to demonstrate the difference.

If you have already started ADHD medication, please also complete the CADDRA Patient ADHD Medication Form. If not, keep the form on hand for possible future use.

- CADDRA Patient ADHD Medication Form

### Information Sheets

Please read the information provided and note any questions to discuss at your next appointment.

- CADDRA ADHD Information and Resources

### Points to discuss at the next medical appointment:

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Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

## CADDRA Teacher Instructions

Name of the educator: \_\_\_\_\_

Name of the student: \_\_\_\_\_ Date: \_\_\_\_\_

Number of hours spent with the student per week: \_\_\_\_\_

Time period for which the form was filled out: \_\_\_\_\_

Hello,

Your student, \_\_\_\_\_, is presently under medical evaluation. To assist with this process, his/her doctor would appreciate your observations on his/her functioning in class. Your feedback will be important in providing knowledge of the student's functioning in the school setting.

As his/her teacher, you are a key part of his/her learning process. We thank you for your input and your assistance in better assessing the needs of this student. The objectives of these forms are to reach an accurate diagnosis and offer interventions and therapeutic solutions that will be individualized for this student.

If you are unsure of your response, go with your first instinct. Do not leave any items blank.

### Questionnaires

Please complete:

- CADDRA Teacher Assessment Form
- Weiss Symptom Record
- SNAP-IV 26 or ADHD Checklist

**Please use this section for other details or comments you would like to provide to your student's doctor:**

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Physician Name: \_\_\_\_\_

MRN/File No: \_\_\_\_\_

Date: \_\_\_\_\_

## CADDRA Adult Assessment Instructions

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of the person who knows you well and will also be completing the questionnaires:  
\_\_\_\_\_

Time period for which the form was filled out: \_\_\_\_\_

If you were on medication when this was completed, what medication were you on? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are presently being evaluated for Attention Deficit Hyperactivity Disorder. During this process, your doctor will need you and someone who knows you well (significant other, family member, roommate or close friend) to complete the following questionnaires. (All of these questionnaires can be downloaded and printed from the Guidelines section on the CADDRA website: [www.caddra.ca](http://www.caddra.ca)). Your input is very important but please do not worry about answering the questions incorrectly. There are no right or wrong answers. You will be asked questions about how you function in a variety of different ways. If you are unsure of an answer, go with your first instinct. Individual questions are less important than the scale as a whole.

### Questionnaires

- Weiss Symptom Record: To be completed by you and someone who knows you well for a long time.
- The ADHD Checklist: Please complete based on how you were as a child, or have a parent complete it for you
- Weiss Functional Impairment Rating Scale-Self Report (WFIRS-S): To be completed by yourself
- Weiss Functional Impairment Rating Scale-Parent Report (WFIRS-P): To be completed by both parents, (you can also try to complete it by yourself if you wish)
- Adult Self Report Scale (ASRS-V1.1, 18 item)

If you are taking medication, you may also complete the forms both on and off medication. Please fill out your answers in two different colours to demonstrate the differences.

If you can find old report cards or any assessments that were completed as a child or adult, please bring them to your appointment. If you have already started on ADHD medication, please also complete the CADDRA Patient ADHD Medication Form, or keep it on hand for possible future use.

- Old report cards or childhood/adult assessments
- CADDRA Patient ADHD Medication Form

### Information Documents

Please read through the information sheets that we have provided and make a note of any questions that you would like to discuss.

- CADDRA ADHD Information and Resources

### Points to discuss at the next medical appointment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_