ATTENTION MD

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Thank you for your interest in our services. Please complete the enclosed questionnaires as carefully & thoroughly as possible. Any previous evaluations or reports you can include are helpful. Dr. Mason will personally evaluate these records prior to the initial appointment to understand your history.

ADHD DIAGNOSTIC EVALUATION COSTS

Questionnaires review & Dr. Mason's evaluation of the information *before* the initial appointment	$110.00	CPT code 96116
Initial appointment with Dr. Mason (85-90 min)	$325.00	CPT code 99204
Neuropsychological computerized diagnostic test	$135.00	CPT code 96130

Full payment of $570.00 is expected upon virtual checkout at the time of service.
It would be very beneficial to include a significant other or spouse at your initial appointment. This person's perspective can be very helpful.

****PLEASE NOTE: WE DO NOT BILL OR PARTICIPATE WITH ANY INSURANCE COMPANIES****

We do provide you with the forms necessary to submit a claim, and your insurance company reimburses *you* according to your out-of-network benefit contract with them. We encourage you to call your insurance company to discuss your benefits using the CPT codes noted above.

CANCELLATION POLICY

If you need to cancel your initial appointment, you must do so **AT LEAST 72 HOURS IN ADVANCE**. Follow-up appointments require 24 hours notice. Missed appointments and cancellations after these deadlines incur the following fees: $50.00 for follow-up appointments; $100 for an initial appointment. If you miss your initial appointment we will request the $100 be paid before adding you back on to the schedule, which can be several months out or longer.

FOLLOW-UP APPOINTMENTS

The staff will be contacting you as your initial appointment approaches to schedule your first 3 follow-up appointments, each in one-month intervals after your initial appointment. We do our best to accommodate your schedule but our appointment availability can be extremely limited. The cost is $165.00 per appointment (CPT code 99214), payable upon virtual check-out.

After your first 3 follow-up visits, frequency of appointments are every 1-3 months based on individual needs and complexity, until treatment is stabilized. Due to regulations regarding controlled substances, most patients appointment frequency requires 3-4 visits per year.

Please do not hesitate to contact our office if you have any questions.
We look forward to meeting you and welcoming you to our practice!

I have read the above and agree:

Signed: _____ Date: _____

Patient Information	
Date of Birth:	Today's date:
Last Name:	First Name: M ☐ F ☐
Address:	City, State, Zip
Landline phone:	Cell phone:
Email address:	
Emergency contact:	Contact's phone:

Responsible Party Information (if different than above)	or check here if same as above
Last Name:	First Name:
Address:	City, State, Zip
Landline phone:	Cell phone:
How is this person related to patient?:	

Insurance Information **(for printing on claim forms)**	
Insurance Company:	
ID#:	Group #:
Subscriber's Name:	Subscriber's DOB:
Patient's Relationship to Subscriber:	

ATTENTION MD

ADULT ADHD & MEDICAL HISTORY

Name: Age:

Occupation:

Were you ever diagnosed with ADHD in the past? (If yes, when and where were you diagnosed and explain what type of testing you may have had.)

If you can provide records from your diagnosis, please include them.

What are the problems that led you to seek consultation now?

When did it first occur to you that you may have ADHD?

What difficulties do you have with attention, organization and task completion?

Were they present as a child?

What difficulties do you have with impulsivity—doing things without thinking them through? Were similar issues present in child or teenage years?

What difficulties do you have with restlessness, talkativeness or hyperactivity? Were they present as a child?

Medications for AD/HD

Please list all AD/HD medications you use ***currently***

Medication name	*Dose*	*Frequency*	*Used every day?*

Additional Notes:

Past Medications for AD/HD

Please list all AD/HD medications you have tried in the past.

Medication name	*Dose*	*Frequency*	*Why stopped?*

Additional Notes:

Who encouraged you to be diagnosed?

Who referred you to Attention MD?

GENERAL MEDICAL HISTORY

List any current medical problems

(Diagnosis)	(Date)	(Treatment)

HT WT Any recent weight changes?

Following is a list of various medical disorders. Please check any that apply to you and explain further in the right hand column:

Diagnosis Date diagnosed Outcome (resolved, still present, etc.)

- ☐ Coronary artery disease
- ☐ Cardiac arrhythmia
- ☐ Heart valve disorder
- ☐ Hypertension
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Cancer or tumors
- ☐ Concussion, head injury
- ☐ Epilepsy or seizure disorder
- ☐ Tic or movement disorder
- ☐ Encephalitis (brain infection)
- ☐ Meningitis
- ☐ Migraine headaches
- ☐ Other headaches
- ☐ Fainting, loss of consciousness (without trauma)
- ☐ Stroke
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Repeated ear infections
- ☐ Speech difficulties
- ☐ Thyroid disease
- ☐ Asthma
- ☐ Seasonal allergies
- ☐ Emphysema, chronic lung condition
- ☐ GE reflux
- ☐ Peptic ulcer disease
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Irritable bowel syndrome
- ☐ Urinary tract infections
- ☐ STD history
- ☐ Skin condition (eczema, etc.)
- ☐ Arthritis
- ☐ Unusual childhood illnesses
- ☐ Birth complications

Men only:

☐ Prostate disorder
☐ Fathered unplanned pregnancy

Women only:

☐ Menopause
☐ Irregular periods
☐ Pelvic infections
☐ Unplanned pregnancy

Current birth control method?
How many pregnancies have you had?
children were born live?
miscarriages?
stillborn babies?
abortions?

☐ Any serious childbirth complications?

Allergies or severe side effects to medications?

Medications causing allergies:	Reaction (hives, nausea, etc.)
1.	
2.	
3.	
4.	
5.	
6.	

Have you ever been hospitalized or had surgery?

Problem	Date

When was your last complete physical exam?

Name and address of primary care physician:

Name(s) and address(es) of other treating physician(s)/therapist(s):

Medications NOT for AD/HD

Please list all medications you use whether daily or "as-needed". Include all vitamins, supplements and over-the-counter medications: *(Note that ADD/ADHD medications have been listed separately.)*

Medication name	***Dose***	***Frequency***	***Used every day?***

Additional Notes:

SYSTEMS REVIEW

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

Frequency	Never	<4/year	<1/month	<1/week	1-3/week	nearly daily
Chest pain with exertion	☐	☐	☐	☐	☐	☐
Chest pain NOT with exertion	☐	☐	☐	☐	☐	☐
Rapid heartbeat	☐	☐	☐	☐	☐	☐
Irregular heartbeat	☐	☐	☐	☐	☐	☐
Dizziness/lightheadedness with exertion	☐	☐	☐	☐	☐	☐
Fainting	☐	☐	☐	☐	☐	☐
Urinary slowing	☐	☐	☐	☐	☐	☐
Irregular periods (women)	☐	☐	☐	☐	☐	☐
PMS (women)	☐	☐	☐	☐	☐	☐
Difficulty achieving or maintaining erections (men)	☐	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐
Stomach pain	☐	☐	☐	☐	☐	☐
Vomiting, nausea	☐	☐	☐	☐	☐	☐
Dry mouth	☐	☐	☐	☐	☐	☐
Tics, unusual body movements	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐	☐	☐

FAMILY HISTORY

*Please indicate which, if any, of the following **blood relatives** have these listed disorders.*

	Birthfather	Birthmother	Siblings	Paternal relatives	Maternal relatives
ADD/ADHD diagnosed	☐	☐	☐	☐	☐
ADD/ADHD suspected	☐	☐	☐	☐	☐
Learning disabilities, dyslexia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Bipolar disorder, manic-depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	☐
OCD (Obsessive Compulsive Disorder)	☐	☐	☐	☐	☐
Tics or Tourette's disorder	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐
Heart attack before age 65	☐	☐	☐	☐	☐
Sudden death	☐	☐	☐	☐	☐
Other heart conditions	☐	☐	☐	☐	☐
Alcohol abuse, alcoholism	☐	☐	☐	☐	☐
Other substance abuse	☐	☐	☐	☐	☐
Incarceration: prison sentence	☐	☐	☐	☐	☐
Physical abuse victim	☐	☐	☐	☐	☐
Physical abuse perpetrator	☐	☐	☐	☐	☐
Sexual abuse victim	☐	☐	☐	☐	☐
Sexual abuse perpetrator	☐	☐	☐	☐	☐
Aggressive, defiant, oppositional as a child	☐	☐	☐	☐	☐
Dropped out of school	☐	☐	☐	☐	☐

Are there any other medical conditions that run in your families?

ACADEMIC HISTORY

Are you currently attending school? ☐ Yes ☐ No

If yes, name of school, level attained:

If not, how far did you go in school?

Name of last school:

Why did you decide to stop at that point?

What were your grade point averages?
High School GPA: College GPA:

Did attention difficulties impact your performance?

Did teachers ever suggest that you were performing less than your abilities?

What comments were typical from your teachers?

Describe your study habits:

Were there any subjects which you could not do no matter how hard you tried?
If so, which one(s)?

Did you repeat any grades? ☐ Yes ☐ No If so, which ones?

Did you ever receive any special education services? ☐ Yes ☐ No If so, please describe:

What were your best subjects?

Have you ever had formal IQ testing? ☐ Yes ☐ No If yes, when?
Do you know your score?

SOCIAL HISTORY

Please list everyone who lives in your home with you.

Are you married, single, single with a partner, divorced or widowed?

Describe or list any prior long-term relationships:

If you are married or living with a partner
Please rate your relationship:

(poor)		(fair)		(average)		(good)		(excellent)	
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Are you adopted? ☐ Yes ☐ No

Do you have children? *(Please list including date of birth. Indicate any adopted/foster children with an asterisk [*].)*

Did you place any children for adoption?

What are your hobbies or spare time interests?

WORK HISTORY
Describe your current occupation:

When did you begin this job?

Briefly explain the other jobs you have held in adulthood. Include the type of work and how long you held the job:

Were you ever fired from a job? ☐ Yes ☐ No If yes, how many times?

HABITS
Do you smoke? ☐ Yes ☐ No If not, did you smoke in the past? ☐ Yes ☐ No
If yes to either question, what age did you begin smoking?

What was your average use of cigarettes in packs per day?

If you quit, what age did you finally accomplish this?

Do you drink alcohol? ☐ Yes ☐ No
If yes, what is the average number of drinks you have ***in one week***? *(One can [12 oz.] of beer, one glass of wine and one ounce [a shot glass] of distilled spirits all equal one drink.)*

What is the highest number of drinks you have had ***in one day*** in the last year?

Have you ever been convicted of DUI? *(Driving Under the Influence of alcohol)* ☐ Yes ☐ No

Has anyone ever suggested to you that you have a "drinking problem"? ☐ Yes ☐ No

Have you used any illegal drugs in the past year? ☐ Yes ☐ No . If yes, please specify:

Have you used any legal drugs illegally in the past year? This includes use of a friend's prescription medicine, illegal purchase of prescription drugs ☐ Yes ☐ No If yes, please specify:

Have you used any illegal drugs in the remote past? ☐ Yes ☐ No . If yes, please specify:

Please give an estimate of your usual caffeine intake per day.
cups of coffee
cups of tea
caffeinated colas, Mountain Dew, etc.

Legal
Have you ever been in trouble with the law? ☐ Yes ☐ No If yes, please specify:

Driving
How many traffic accidents have you had? How many accidents were your fault?

How many speeding tickets? How many other traffic tickets?

Finances
Have you gambled with money that was needed for other purposes? ☐ Yes ☐ No
Has gambling ever caused other problems for you? ☐ Yes ☐ No
How much have you lost gambling in one year?

Have you ever gotten into credit trouble? ☐ Yes ☐ No
Do you have financial trouble related to overspending? ☐ Yes ☐ No
Have you had financial trouble related to difficulty managing bills? ☐ Yes ☐ No

Internet
Do you often use the Internet or games when you should be sleeping or doing more essential things? ☐ Yes ☐ No
Do you have any addictions such as
Facebook? ☐ Yes ☐ No
Gambling? ☐ Yes ☐ No
Pornography? ☐ Yes ☐ No

MENTAL HEALTH HISTORY

Check any diagnoses YOU have received in the past:

Diagnosis	Date of diagnosis	Treatment	Outcome
☐ Depression			
☐ Bipolar disorder			
☐ Anxiety and/or panic			
☐ Obsessive compulsive disorder			
☐ Learning disability			
☐ Alcohol, substance abuse			
☐ Asperger, autism			
☐ Sensory Integration Disorder			
☐ Schizophrenia			
☐ Other mental disorder			

Counseling

Are you currently in counseling? ☐ Yes ☐ No

If so, with whom?

If yes-what is the focus of your counseling?

Have you ever previously been in counseling? ☐Yes ☐ No

Was the counseling helpful?

Hospitalization

Were you ever hospitalized for any mental health problems? ☐ Yes ☐ No If so, please describe.

Have you ever attempted suicide? ☐ Yes ☐ No If so, please describe the circumstances

Situational fears:

No	Sometimes	Often	
☐	☐	☐	Unrealistic worry about the possibility of harm to a loved one
☐	☐	☐	Unrealistic fear of death or calamity
☐	☐	☐	Refusal to leave home or distress when away from home
☐	☐	☐	Specific fear: flying, heights, spiders, snakes, blood, injections, etc.
			Please specify:

Further explanation that may be helpful:

Anxiety, fear, worry:

No	Sometimes	Often	
☐	☐	☐	Unrealistic worry about future events
☐	☐	☐	Unrealistic worry about appropriateness of past behavior
☐	☐	☐	Unrealistic concern about competence
☐	☐	☐	Marked self-consciousness
☐	☐	☐	Need for details and reassurance when looking forward to new experiences
☐	☐	☐	Difficulty relaxing
☐	☐	☐	Dislike being observed in public; marked performance anxiety
☐	☐	☐	Easily embarrassed in public
☐	☐	☐	Avoid social situations
☐	☐	☐	Nail biting or any other nervous habit

Further explanation that may be helpful:

Obsessions, compulsions:

No	Sometimes	Often	
☐	☐	☐	Recurrent thoughts, urges, images that cause anxiety
☐	☐	☐	Repetitive behaviors (picking at skin, hand washing, checking, ordering)
☐	☐	☐	Repetitive mental acts (praying, counting, repeating words) in response to a troubling thought
☐	☐	☐	Unable to stop pulling, twirling hair
☐	☐	☐	Preoccupied with physical appearance
☐	☐	☐	Preoccupied with sexual thoughts

Further explanation that may be helpful:

Depression symptoms:

No	Sometimes	Often	
☐	☐	☐	Depressed or sad mood most of the day, nearly every day
☐	☐	☐	Irritability, sullenness, anger most of the day, nearly every day
☐	☐	☐	Diminished pleasure in activities; loss of interest in hobbies, interests
☐	☐	☐	Crying, easy tearfulness
☐	☐	☐	Change in appetite—either a decrease or an increase
☐	☐	☐	Excessive sleeping or trouble getting to sleep/staying asleep
☐	☐	☐	Diminished interest in friends, social activities
☐	☐	☐	Fatigue or loss of energy
☐	☐	☐	Feeling of worthlessness or excessive guilt
☐	☐	☐	Diminished ability to concentrate, indecisiveness below your usual baseline
☐	☐	☐	Feelings of hopelessness
☐	☐	☐	Recurrent thoughts of death, suicidal thought or attempts

Further explanation that may be helpful:

Mood symptoms:

No	Yes	
☐	☐	Has there ever been a specific period or periods of time when you were not yourself and had one or more of the following symptoms? If yes, check the symptoms that occurred during the time(s) you have in mind.
☐	☐	Unrealistically high self-esteem, self-confidence or grandiosity
☐	☐	Decreased need for sleep (e.g., feeling rested after only 3 hours of sleep)
☐	☐	Irritability that led to shouting at people or starting fights or arguments
☐	☐	Thoughts racing and tumbling
☐	☐	More talkative than usual or pressure to keep talking
☐	☐	Unusually high physical and/or sexual energy
☐	☐	Unusually risky or foolhardy activities (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

Further explanation that may be helpful:

Sleep pattern:

No	Sometimes	Often	
☐	☐	☐	Trouble falling asleep
☐	☐	☐	Trouble staying asleep—nighttime awakening
☐	☐	☐	Early morning awakening
☐	☐	☐	Difficulty arising in the morning
☐	☐	☐	Sleepiness or falling asleep during the day
☐	☐	☐	Snoring
☐	☐	☐	Apnea—stopping breathing
☐	☐	☐	Unusually severe or persistent nightmares

Typical number of hours of sleep per night:

Further explanation that may be helpful:

Post-traumatic symptoms:

No	Sometimes	Often	
☐	☐	☐	Recurring memories of past traumas
☐	☐	☐	Recurring dreams of past events
☐	☐	☐	Daydreams or flashbacks of past events
☐	☐	☐	Intense stress in specific situations that somehow connect to past events
☐	☐	☐	Unable to remember important aspects of past events

Further explanation that may be helpful:

ADULT ADHD QUESTIONNAIRE

Name: Date: 1_____ 2_____ 3_____ 4_____

Respond with the degree to which these apply to you. As you answer these questions, try to consider primarily the last two to four weeks.

	Not at all	Just a little	Pretty much	Very much
Attention and Organization				
Difficulty or inefficiency organizing tasks and activities	☐	☐	☐	☐
Easily distracted by extraneous stimuli	☐	☐	☐	☐
Difficulty sustaining attention in tasks or leisure activities	☐	☐	☐	☐
Make decisions impulsively, without considering consequences/outcomes	☐	☐	☐	☐
Poor follow-through on promises or commitments	☐	☐	☐	☐
Likely to drive a motor vehicle much faster than others	☐	☐	☐	☐
Start tasks without reading or listening to directions carefully	☐	☐	☐	☐
Have trouble doing things in their proper order or sequence	☐	☐	☐	☐
Difficulty stopping activities when they should do so	☐	☐	☐	☐
Poor time sense, trouble managing time efficiently	☐	☐	☐	☐
Trouble listening when spoken to directly	☐	☐	☐	☐
Procrastinate or struggle to begin tasks that require sustained mental effort.	☐	☐	☐	☐
Restlessness and Control of Activity Level				
Uncomfortable doing things slowly and systematically; rush through activities or tasks	☐	☐	☐	☐
Impatient; hard to wait on others	☐	☐	☐	☐
Difficulty resisting opportunities or temptations	☐	☐	☐	☐
Tend to act without thinking, make important decisions on the spur of the moment	☐	☐	☐	☐
Interrupt others	☐	☐	☐	☐
Difficulty waiting turn, avoid lines, stoplights	☐	☐	☐	☐
Complete others sentences, "jump the gun" in conversation	☐	☐	☐	☐
Require effort to wait turn	☐	☐	☐	☐
Talk too much	☐	☐	☐	☐
"On the go", always moving	☐	☐	☐	☐
Loud	☐	☐	☐	☐
Restless when staying seated is required	☐	☐	☐	☐
Emotional Self-control				
Anxious, worried, stressed	☐	☐	☐	☐
Avoid social situations, people interactions	☐	☐	☐	☐
Short fuse, easily angered	☐	☐	☐	☐
Blurt out or say things without thinking	☐	☐	☐	☐
Easily frustrated	☐	☐	☐	☐
Often wish I could take back comments	☐	☐	☐	☐
Self-centered, forget to think of others	☐	☐	☐	☐
Throw tantrums	☐	☐	☐	☐
Forget manners, impolite	☐	☐	☐	☐
Moods unpredictable	☐	☐	☐	☐
Feelings of hopelessness	☐	☐	☐	☐
Loss of interest in pleasurable activities	☐	☐	☐	☐
Well-being				
Not sure of self	☐	☐	☐	☐
Wish I had greater self-confidence	☐	☐	☐	☐
Disbelieve positive feedback from others	☐	☐	☐	☐
Act OK outside but unsure of self	☐	☐	☐	☐
Feel unhappy	☐	☐	☐	☐
Avoid new challenges	☐	☐	☐	☐

Adult Self-Report Scale (ASRS)

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, circle the correct number that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed questionnaire to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often	Score
Patient Name	**Today's Date**					
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐	
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐	
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐	
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐	
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐	
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐	
7. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐	
8. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐	
9. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐	
	Part A – Total					
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐	
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐	
12. How often do you feel restless or fidgety?	☐	☐	☐	☐	☐	
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐	
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐	
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 them 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?	☐	☐	☐	☐	☐	
	Part B – Total					

WEISS FUNCTONAL IMPAIRMENT RATING SCALE SELF—REPORT (WFIRS-S)

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

A. Family Issues

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	Not Applicable
1.	Have problems with family	☐	☐	☐	☐	☐
2.	Have problems with spouse/partner	☐	☐	☐	☐	☐
3.	Rely on others to do things for you	☐	☐	☐	☐	☐
4.	Cause fighting in the family	☐	☐	☐	☐	☐
5.	Make it hard for the family to have fun together	☐	☐	☐	☐	☐
6.	Have problems taking care of family	☐	☐	☐	☐	☐
7.	Problems balancing your needs against those of your family	☐	☐	☐	☐	☐
8.	Problems losing control with the family	☐	☐	☐	☐	☐

B. Work

1.	Problems performing required duties	☐	☐	☐	☐	☐
2.	Problems with getting your work done efficiently	☐	☐	☐	☐	☐
3.	Problems with your supervisor	☐	☐	☐	☐	☐
4.	Problems keeping a job	☐	☐	☐	☐	☐
5.	Getting fired from work	☐	☐	☐	☐	☐
6.	Problems working in a team	☐	☐	☐	☐	☐
7.	Problems with your attendance	☐	☐	☐	☐	☐
8.	Problems with being late	☐	☐	☐	☐	☐
9.	Problems taking on new tasks	☐	☐	☐	☐	☐
10.	Problems working to your potential	☐	☐	☐	☐	☐
11.	Poor performance evaluations	☐	☐	☐	☐	☐

C. School

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	Not Applicable
1.	Excessive use of TV, computer, or video games	☐	☐	☐	☐	☐
2.	Problems completing assignments	☐	☐	☐	☐	☐
3.	Problems getting your work done efficiently	☐	☐	☐	☐	☐
4.	Problems with teachers	☐	☐	☐	☐	☐
5.	Problems with school administrators	☐	☐	☐	☐	☐
6.	Problems meeting minimum requirements to stay in school	☐	☐	☐	☐	☐
7.	Problems with attendance	☐	☐	☐	☐	☐
8.	Problems with being late	☐	☐	☐	☐	☐
9.	Problems working to your potential	☐	☐	☐	☐	☐
10.	Problems with inconsistent grades	☐	☐	☐	☐	☐

D. Life Skills

1.	Excessive or inappropriate use of TV, computer, or video games	☐	☐	☐	☐	☐
2.	Problems keeping an acceptable appearance	☐	☐	☐	☐	☐
3.	Problems getting ready to leave the house	☐	☐	☐	☐	☐
4.	Problems getting to bed	☐	☐	☐	☐	☐
5.	Problems with nutrition	☐	☐	☐	☐	☐
6.	Problems with sex	☐	☐	☐	☐	☐
7.	Problems with sleeping	☐	☐	☐	☐	☐
8.	Get hurt or injured	☐	☐	☐	☐	☐
9.	Avoid exercise	☐	☐	☐	☐	☐
10.	Problems keeping regular appointment with doctor or dentist	☐	☐	☐	☐	☐
11.	Problems keeping up with household chores	☐	☐	☐	☐	☐
12.	Problems managing money	☐	☐	☐	☐	☐

D. Self-Concept

1.	Feel bad about yourself	☐	☐	☐	☐	☐
2.	Feel frustrated with yourself	☐	☐	☐	☐	☐
3.	Feel discouraged	☐	☐	☐	☐	☐
4.	Don’t feel happy with your life	☐	☐	☐	☐	☐
5.	Feel incompetent	☐	☐	☐	☐	☐

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	Not Applicable

E. Social Activities

1.	Get into arguments	☐	☐	☐	☐	☐
2.	Trouble cooperating	☐	☐	☐	☐	☐
3.	Trouble getting along with people	☐	☐	☐	☐	☐
4.	Problems having fun with other people	☐	☐	☐	☐	☐
5.	Problems participating in hobbies	☐	☐	☐	☐	☐
6.	Problems making friends	☐	☐	☐	☐	☐
7.	Problems keeping friends	☐	☐	☐	☐	☐
8.	Say inappropriate things at times	☐	☐	☐	☐	☐
9.	Receive complaints from neighbors	☐	☐	☐	☐	☐

F. Risk

1.	Aggressive driving	☐	☐	☐	☐	☐
2.	Do other things while driving	☐	☐	☐	☐	☐
3.	Road rage	☐	☐	☐	☐	☐
4.	Break or damage things	☐	☐	☐	☐	☐
5.	Do things that are illegal	☐	☐	☐	☐	☐
6.	Involved with the police	☐	☐	☐	☐	☐
7.	Smoke cigarettes, use tobacco	☐	☐	☐	☐	☐
8.	Smoke marijuana	☐	☐	☐	☐	☐
9.	Drink alcohol	☐	☐	☐	☐	☐
10.	Take “street drugs”	☐	☐	☐	☐	☐
11.	Sex without protection (birth control, condom)	☐	☐	☐	☐	☐
12.	Inappropriate sexual behavior	☐	☐	☐	☐	☐
13.	Physically aggressive behavior	☐	☐	☐	☐	☐
14.	Verbally aggressive behavior	☐	☐	☐	☐	☐

DO NOT WRITE IN THIS AREA	
A. Family	
B. Work	
C. School	
D. Life skills	
E. Self-concept	
F. Social	
G. Risk	
Total	

Thank you for the considerable effort you have taken to complete this work