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Quick Adult ADHD Screening Test

Patient Name: _____ Sex: M ___ F ___ Age: _____

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

		Never	Rarely	Sometimes	Often	Very Often
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 and 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?					