ASRS Symptoms Checklist

Patient Name	**Today's Date**

Please answer the questions below, rating your child 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 they have felt and conducted over the past 6 months.	**Never**	**Rarely**	**Sometimes**	**Often**	**Very Often**
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	**0**	**1**	**2**	**3**	**4**
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	**0**	**1**	**2**	**3**	**4**
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	**0**	**1**	**2**	**3**	**4**
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	**0**	**1**	**2**	**3**	**4**
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	**0**	**1**	**2**	**3**	**4**
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	**0**	**1**	**2**	**3**	**4**
7. How often do you misplace or have difficulty finding things at home or at work?	**0**	**1**	**2**	**3**	**4**
8. How often are you distracted by activity or noise around you?	**0**	**1**	**2**	**3**	**4**
9. How often do you have problems remembering appointments or obligations?	**0**	**1**	**2**	**3**	**4**
			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?	**0**	**1**	**2**	**3**	**4**
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	**0**	**1**	**2**	**3**	**4**
12. How often do you feel restless or fidgety?	**0**	**1**	**2**	**3**	**4**
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	**0**	**1**	**2**	**3**	**4**
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	**0**	**1**	**2**	**3**	**4**
15. How often do you find yourself talking too much when you are in social situations?	**0**	**1**	**2**	**3**	**4**
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?	**0**	**1**	**2**	**3**	**4**
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	**0**	**1**	**2**	**3**	**4**
18. How often do you interrupt others when they are busy?	**0**	**1**	**2**	**3**	**4**
			Part B-Total		

Patients Name:_____ Today's Date:_____

Anxiety & Depression Assessment:	**Never**	**Sometimes**	**Often**	**Very Often**
A. Is fearful, anxious, or worried	0	1	2	3
A. Is afraid to try new things for fear of making mistakes	0	1	2	3
A. Is self-conscious or easily embarrassed	0	1	2	3
D. Feels worthless or inferior	0	1	2	3
D. Blames Self for problems, feels guilty	0	1	2	3
D. Feels lonely, unwanted, or unloved, complains that, "no one loves him or her"	0	1	2	3
D. Is sad, unhappy, or depressed	0	1	2	3

Side Effects: Have you or your child/student experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	Never	**Sometimes**	**Often**	**Very Often**
Headache				
Stomachache				
Change of appetite-explain below				
Trouble Sleeping				
Irritability in the late morning, late afternoon, or evening-explain below				
Socially withdrawn-Decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired listless behavior				
Tremors/felling shaky				
Repetitive movements ties, jerking, twitching, eye blinking, explain below				
Picking at skin or fingers, nail biting, lip or check chewing-explain below				
Hears or sees things that aren't there				

Explain/Comments: