SAMPLE ADHD ASSESSMENT — ADULT PSYCHIATRY

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1 Patient Information

1 PATIENT DETAILS

Name
Nathan C. Broderick

Assessment Date
05/06/2026

DOB / Age / Sex
03/27/1992 | 34M

Provider
Dr. Suzanne M. Holt, MD — Adult Psychiatry

MRN

Referral Source
Self-referred after reading about adult ADHD; PCP confirmed no prior psychiatric history on record.

CC Chief Complaint & HPI

2 PRIMARY CONCERN

Mr. Broderick presents requesting evaluation for ADHD. He reports lifelong difficulties with sustained attention, organization, and task completion that have significantly worsened since starting a demanding project management role 18 months ago. He states, 'I've always struggled to finish things, but now it's affecting my job and my marriage.'

3 HISTORY OF PRESENT ILLNESS

Mr. Broderick is a 34-year-old married male employed as a senior project manager at a software firm who presents with a lifelong history of attention and organizational difficulties that he reports have been present since at least elementary school. He recalls frequently losing items (backpack, homework), difficulty sitting through class, and teachers' comments that he 'wasn't living up to his potential.' He attended college with significant academic difficulty, changing majors twice, and required an extra year to complete his degree. He compensated through hyperfocus on topics of interest (gaming, technology) and developed external organizational systems (multiple apps, sticky notes, alarms) that partially offset his deficits. His current role requires sustained attention during long meetings, multi-project tracking, and deadline management — all areas in which he reports consistent failure. Over the past 18 months, he has received two formal performance warnings. His wife reports that he frequently forgets household responsibilities, loses important documents, and struggles to complete conversations without interrupting. He has not previously received ADHD evaluation or stimulant medication. He completed the Adult ADHD Self-Report Scale (ASRS v1.1) prior to this visit — score of 46/72 (significantly elevated; clinical threshold ≥36).

DH Developmental & Educational History

4a DEVELOPMENTAL HISTORY

Born full-term, no perinatal complications reported. Developmental milestones within normal limits per maternal history. First-grade teacher notes (obtained by patient) document 'difficulty staying on task and frequently out of seat.' Speech articulation therapy in grade 2. No learning disability diagnosis formally made. High motor activity noted throughout childhood — 'always climbing or fidgeting' per patient report.

4b EDUCATIONAL / OCCUPATIONAL HISTORY

Attended public schools in suburban Ohio. GPA ranged 2.2–2.8 throughout high school — discrepant from IQ estimate (administered in 10th grade at 118 — high average range). Multiple incomplete assignments and 'missing work' documented in school records. Graduated college in 5 years (Communications/Business double major). Currently employed 8 years with 2 performance improvement plans in current role (past 18 months). Prior employment in sales — moderately successful — changed jobs frequently (every 2–3 years), often due to boredom.

SX DSM-5 Symptom Assessment

5a INATTENTION SYMPTOMS

Mr. Broderick endorses all 9 DSM-5 inattention criteria: (1) Frequently makes careless errors in project reports and financial documents — caught by team members rather than himself. (2) Cannot sustain attention during meetings lasting more than 20 minutes without active note-taking — often loses track of the topic. (3) Does not listen when directly spoken to — wife reports 'glazed over' look during conversations. (4) Fails to follow through on instructions — starts tasks, gets distracted, abandons them partially complete. (5) Significant difficulty organizing work projects and home finances — bills paid late despite adequate income. (6) Avoids and delays tasks requiring sustained mental effort (expense reports, performance reviews). (7) Loses wallet, phone, and car keys on a weekly basis. (8) Easily distracted by background noise, phone notifications, and tangential thoughts during focused work. (9) Forgetful in daily activities — misses medical appointments, forgets to pick up children from school on two occasions.

5b HYPERACTIVITY / IMPULSIVITY SYMPTOMS

Endorses 5 of 9 DSM-5 hyperactivity/impulsivity criteria: Fidgets constantly — taps feet and clicks pen throughout this interview. Leaves seat during long meetings under pretense of getting coffee. Reports feeling internal restlessness — 'like a motor is always running.' Talks excessively in social settings — wife confirms. Interrupts others during conversations — acknowledged as a significant relationship stressor.

Number of Criteria Met
9/9 inattention criteria met; 5/9 hyperactivity/impulsivity criteria met (above the threshold of ≥5 for adults age >17).

Duration Present
Symptoms clearly present since at least age 7 (first grade documentation). Duration exceeds 6-month requirement — symptoms present for 27+ years.

Settings Where Present
Symptoms present in workplace, home, social, and academic settings — full cross-situational impairment confirmed by both patient self-report and wife's collateral information (spouse questionnaire completed).

FI Functional Impairment & Background

6a FUNCTIONAL IMPAIRMENT

Occupational impairment: Two performance improvement plans in 18 months; near-termination risk; estimated 40% productivity loss. Relationship impairment: Wife reports frustration with forgetfulness and incomplete household responsibilities; marital counseling initiated last year. Financial: Bills paid late despite sufficient income; one credit score impact from missed payment. Parenting: Two instances of forgetting school pickup in past 6 months. Patient reports significant shame, secondary low self-esteem, and frustration with self.

6b PAST PSYCHIATRIC & MEDICAL HISTORY

No prior psychiatric diagnoses or medication history. Reports symptoms of low self-esteem throughout adolescence — attributed to academic underperformance, not explored in therapy. Saw a counselor briefly in college (3 sessions) for stress — no diagnosis given. Medical: Mild hypertension — on lisinopril 10 mg. No history of seizure disorder, cardiac arrhythmia, or structural heart disease. No history of TBI. Sleep quality poor — evaluated by PCP, no formal sleep study done.

6c MEDICATIONS / FAMILY / SOCIAL HISTORY

Medications: Lisinopril 10 mg PO daily. Occasional ibuprofen PRN. No psychotropic medications. | Family: Brother (age 31): Diagnosed ADHD combined type in adulthood, on amphetamine salts. Father: Suspected ADHD, undiagnosed — history of academic and occupational instability described by patient. No family history of bipolar disorder, schizophrenia, or substance use disorder. | Social: Married 8 years, 2 children (ages 5 and 7). Lives in Columbus, Ohio. Non-smoker. Drinks 2–3 beers on weekends — denies alcohol dependence. Denies illicit drug use. Has tried cannabis twice in past 2 years 'to calm down' — not regular user.

O Objective — Mental Status Examination

MSE MENTAL STATUS

Appearance
Well-groomed male, casually dressed. Arrived 12 minutes late to appointment (apologized; attributed to losing his keys).

Behavior
Visible fidgeting — leg bouncing, pen clicking throughout the interview. Left chair twice to get water from the hall without apparent awareness. Socially warm and talkative.

Speech

Mood & Affect

Normal rate and volume but tangential — required 4–5 redirections to stay on topic during structured questions. No pressured speech.

Euthymic mood, full range affect. Anxious but appropriate about this evaluation.

Thought Process
Tangential at baseline — improved with structured questioning.

Attention / Concentration
Concentration impaired during this interview — required redirection, easily distracted by sounds from hallway. Serial subtraction (100-7): 5 errors.

Insight
Good — patient demonstrates strong insight into his deficits and their impact on his life.

Judgment
Intact.

SA Standardized Assessment Tools

7 VALIDATED SCALES

Tool Used
Adult ADHD Self-Report Scale (ASRS v1.1)

Scores & Interpretation
ASRS total score: 46/72. Part A (6 items, highest sensitivity): 22/24 — all 6 items rated at 'often' or 'very often.' Clinical threshold ≥36 met. Interpretation: Consistent with significant ADHD symptom burden; formal diagnostic assessment confirmed.

A Assessment

8a DIAGNOSTIC FORMULATION

ADHD Subtype
ADHD, Combined Presentation (meets both inattentive ≥5 and hyperactive-impulsive ≥5 criteria in adults)

Severity
Moderate — significant occupational and relationship impairment; functional impairment present in ≥2 settings

8b DIFFERENTIAL DIAGNOSES & COMORBIDITIES

Primary differential: ADHD Combined Type (confirmed). Other considerations ruled out: (1) Anxiety disorder — mild secondary anxiety present but does not account for the full symptom picture; anxiety developed in response to ADHD-related failures, not a primary disorder. (2) Mood disorder — euthymic, no hypomanic/manic features; no MDD meeting criteria. (3) Sleep disorder — poor sleep quality may exacerbate attention; sleep study to be ordered but does not fully explain lifelong symptoms.

P Plan

9 MANAGEMENT PLAN

1. Diagnosis confirmed: ADHD, Combined Presentation, Moderate. 2. Initiate methylphenidate ER (Concerta) 18 mg PO QAM x4 weeks — low starting dose given history of hypertension; recheck BP at 4-week visit. 3. BP monitoring — patient instructed to purchase home BP cuff; weekly readings logged. 4. Referred for ADHD coaching (structured behavioral strategies, organizational systems). 5. Psychoeducation provided — handout on adult ADHD provided, including common myths and evidence-based strategies. 6. Couples therapy referral provided given relationship impact — patient receptive. 7. Sleep evaluation — primary care referral for polysomnography given poor sleep quality and weight (BMI 29.4). 8. Patient instructed to track medication effectiveness using ASRS monthly. 9. Stimulant medication counseling — appetite suppression, sleep latency, monitoring for mood changes, and substance risk (patient counseled; low concern given history). 10. EKG ordered at baseline given methylphenidate initiation per guidelines.

F Follow-Up

10 REASSESSMENT

Follow-up timeline
Return in 4 weeks for medication response evaluation — BP check, ASRS re-administration, adverse effects review. Dose adjustment anticipated at that visit (target 36–54 mg range). Contact office sooner if BP >150/95, palpitations, mood changes, or significant insomnia.

TIME DOCUMENTATION & BILLING

Total Time

Counseling Time

E/M Level
99205 — New patient, high complexity, plus 96130 — Psychological testing evaluation

Basis

Medical Decision Making — High Complexity with psychological testing evaluation

Primary Dx Code
F90.2 — ADHD, combined type

Secondary Dx Code(s)
I10 — Hypertension; Z73.1 — Type A behavior pattern (occupational/social stressor)

PROVIDER NAME	CREDENTIALS	DATE & TIME
Dr. Suzanne M. Holt, MD — Adult Psychiatry	MD — Adult Psychiatry	05/06/2026