

Adult ADHD Evaluation Record

Criteria walk, instruments used, collateral, and differential

PATIENT AND VISITS

PATIENT NAME OR INITIALS	
RECORD NUMBER	
DATE OF BIRTH	[MM / DD / YYYY]
VISIT 1 DATE AND LENGTH	[MM / DD / YYYY] [Minutes]
VISIT 2 DATE AND LENGTH	[MM / DD / YYYY] [Minutes]
VISIT FORMAT	☐ In person ☐ Audio-video telehealth ☐ Mixed

CRITERIA WALK — ADULTS AGED 17 AND OVER

FIVE OR MORE INATTENTION SYMPTOMS	☐ Yes ☐ No Count: ____ [Which ones]
FIVE OR MORE HYPERACTIVE OR IMPULSIVE SYMPTOMS	☐ Yes ☐ No Count: ____ [Which ones]
SEVERAL SYMPTOMS PRESENT BEFORE AGE 12	☐ Yes ☐ No ☐ Cannot establish [Evidence]
SYMPTOMS IN TWO OR MORE SETTINGS	[Which settings, with an example from each]
CLEAR INTERFERENCE WITH FUNCTIONING	[Work, study, relationships, finances, driving]
NOT BETTER EXPLAINED BY ANOTHER CONDITION	[What was considered and ruled out]

INSTRUMENTS USED

INSTRUMENT 1	[Name and version] Score: ____ Rule used: ____
INSTRUMENT 2	[Name and version] Score: ____ Rule used: ____
CHILDHOOD MEASURE	[Name and version] Score: ____
SCORING RULE NOTE	Where an instrument has more than one published scoring rule, record which one you applied.

SOURCE OF EACH INSTRUMENT	[Publisher or URL. Record that your use is licensed.]
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COLLATERAL

INFORMANT AVAILABLE	☐ Yes ☐ No ☐ Declined by patient
INFORMANT AND RELATIONSHIP	[Who, and to the patient]
WHAT THE INFORMANT REPORTED	[Summary, kept separate from the patient's own report]
IF NO INFORMANT	Record that collateral was sought, what was tried, and why it could not be obtained.
RECORDS REVIEWED	☐ School ☐ Prior treatment ☐ None available

DIFFERENTIAL AND COMORBIDITY

CONSIDERED AND ADDRESSED	☐ Mood ☐ Anxiety ☐ Bipolar ☐ Substance use ☐ Sleep ☐ Trauma ☐ Medical
BASIS FOR EACH EXCLUSION	[Brief reasoning, one line each]
CONCERNS ABOUT SYMPTOM VALIDITY	☐ None noted ☐ Noted [What, and how it was handled]

OUTCOME

DIAGNOSTIC IMPRESSION	[ICD-10 code. Codes are updated annually, so use the current-year edition.]
PRESENTATION	☐ Predominantly inattentive ☐ Predominantly hyperactive-impulsive ☐ Combined
DIAGNOSIS NOT MADE	☐ Criteria not met ☐ Insufficient information [What would be needed]
PLAN	[Treatment, referral, or repeat assessment and when]
IF PRESCRIBING A CONTROLLED SUBSTANCE	Confirm current federal and state telehealth rules apply to this visit format.

CLINICIAN

CLINICIAN NAME AND CREDENTIALS	
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SCOPE	☐ Can prescribe ☐ Cannot prescribe, referral made to []
RECORD STATUS	Scale results and the diagnosis are part of the clinical record. Neither is a psychotherapy note.
CLINICIAN SIGNATURE	
DATE	[MM / DD / YYYY]

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