Central Ohio Counseling, Inc.
ADULT SELF REPORT

Clinician Name:	Date:

This Section For Clinician Use Only

______________________ ______________________
First Name **Last Name**

Name/relationship of person who recommended treatment?

____

____

Briefly describe the problems for which you are currently seeking help:

____

____

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Have you experienced similar or identical symptoms in the past?

○ **Yes** ○ **No**

If yes, how many times?______________

List any questions you would like to have dealt with today.

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Print Your Name: ______________________________

SELF REPORT

Have you ever been in treatment before?   yes   no

If so name/address/phone of therapist or psychiatrist:

____

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Type of treatment received (e.g., Outpatient Counseling, Medication, Hospitalization, etc.)

	Date:_______
______________________________	____________
______________________________	____________
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This Section For Clinician Use Only

Print Your Name:	SELF REPORT	Clinician Print Login Name:
______________________________		______________________________

- **Do you have current medical problems or have you had previous significant illness or surgery?**

☐ **No** ☐ **Yes**

- **If you answered "Yes" please list on the following lines:**

Problem	Approximate Dates

- **Do you now or have you ever had problems with:**

Diabetes	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Mital valve prolapse	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Head injury with loss of consciousness	☐ Yes	☐ No
Liver problems	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Digestive Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

- **Do you have any allergies to medication?**

☐ **No** ☐ **Yes**

- **If "Yes" please list on the following lines:**

____

____

____

- **Do you have any other serious allergies?**

____

____

This Section For Clinician Use Only

- **Are you currently taking any prescription medications?**

  ☐ **No** ☐ **Yes**

  If yes, please complete the following:

Medication	Dosage	Physician	Start Date

- **Weight gain or loss in the past year:** ____________________

- **Average number of hours you sleep nightly?** ______________

  Has that changed recently? ☐ **No** ☐ **Yes**

  Explain if "YES": ______________________________

  ____

  Do you sleep soundly? ☐ **No** ☐ **Yes**

  Explain if "NO": ______________________________

  ____

  ____

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  ____

- **When was your last physical exam?** ____________________

This Section For Clinician Use Only

Print Your Name: ______________________________

SELF REPORT

Clinician Print Login Name: ______________________________

- **Describe your history and present circumstances with your marriage(s) or significant other(s).**

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- **Substance use/abuse:**

Past **Use:**

○ **Yes** ○ **No**

What: ______________________________
____
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____
____

Frequency: ______________________________
____
____

When: ______________________________
____
____

This Section For Clinician Use Only

Current **Use:** ☐ **No** ☐ **Yes**

What: ____

____

Frequency: ____

____

When: ____

____

Other **family member use:** ☐ **No** ☐ **Yes**

What: ____

____

Frequency: ____

____

When: ____

____

- **List career and educational background information:**

____

____

____

- **Military History :**

____

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- **What statement best describes your financial situation:**

____

____

____

- **What statement best describes your current legal situation:**

____

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This Section For Clinician Use Only

Print Your Name: ______________________________	SELF REPORT	Clinician Print Login Name: ______________________________

Below you will find a list of problems which people commonly face. First, read the list carefully and make a check mark next to each problem that you are now having. Second, circle those problems which you believe are the worst or which are causing you the most trouble at this time. Remember, there are no correct or incorrect answers.

- ☐ aggression
- ☐ alcohol dependence
- ☐ anger
- ☐ anxiety
- ☐ avoiding people
- ☐ concentration problems
- ☐ chest pain
- ☐ depression
- ☐ disorientation
- ☐ dizziness
- ☐ disorganized thoughts
- ☐ drug dependence
- ☐ eating disorder
- ☐ fatigue
- ☐ guilt
- ☐ hallucinations
- ☐ heart palpitations
- ☐ irritability
- ☐ isolation
- ☐ insomnia/sleep problems
- ☐ judgement errors
- ☐ loneliness
- ☐ memory impairment
- ☐ mood swings
- ☐ panic attacks
- ☐ paranoid thoughts
- ☐ perfectionism
- ☐ phobias/irrational fears
- ☐ preoccupation with problems
- ☐ sadness
- ☐ sexual difficulties
- ☐ stress/tension
- ☐ suicidal thoughts
- ☐ social withdrawal
- ☐ temper outbursts
- ☐ tearfulness
- ☐ worry
- ☐ not getting along with people
- ☐ financial problems
- ☐ feeling unattractive
- ☐ feeling unpopular
- ☐ job/vocational problems
- ☐ feeling out of control
- ☐ marital problems
- ☐ problems with children
- ☐ medical/health problems
- ☐ health problems of family member
- ☐ feeling abandoned
- ☐ unable to work out religious beliefs
- ☐ legal problems
- ☐ fear of going crazy
- ☐ feeling hopeless
- ☐ feeling like a failure
- ☐ feeling uncared for
- ☐ feelings of being misunderstood
- ☐ feeling unconnected to people
- ☐ sleeping excessively
- ☐ afraid of hurting self
- ☐ afraid of hurting others
- ☐ losing track of time
- ☐ getting too emotional
- ☐ restricting activities
- ☐ feeling attacked
- ☐ following irrational rituals
- ☐ lack of sexual desire
- ☐ feeling unhappy all the time
- ☐ feeling afraid of many things
- ☐ problems with sexual identity
- ☐ having a physical disability
- ☐ being overly influenced by others
- ☐ unable to stop worrying
- ☐ no time for leisure activities
- ☐ no friends
- ☐ no interest in anything

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

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, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	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 or 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?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
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