ADHD Pre-Visit Family Questionnaire

This questionnaire is designed to help individuals and families organize their experiences and concerns before meeting with a physician or licensed professional.

First & Last Name:		Age:	
Date of Birth:		Date Completed:	

Instructions

For each item below, check any statements that apply. Then rate how much this impacts daily life on a scale of 1–5 (1 = Not at all, 5 = Extreme impact).

• Difficulty starting or completing tasks

Applies	1	2	3	4	5

• Trouble focusing unless highly interested

Applies	1	2	3	4	5

• Frequently losing or misplacing items

Applies	1	2	3	4	5

• Time blindness or chronic lateness

Applies	1	2	3	4	5

• Feeling mentally overwhelmed or scattered

Applies	1	2	3	4	5

• Emotional reactivity or intense emotions

Applies	1	2	3	4	5

• Restlessness or feeling internally driven

Applies	1	2	3	4	5

• Interrupting others or difficulty waiting

Applies	1	2	3	4	5

• Forgetfulness in daily responsibilities

Applies	1	2	3	4	5

• Difficulty organizing thoughts or belongings

Applies	1	2	3	4	5

Additional Comments / Examples

This questionnaire is intended to help you and your physician begin the process. It is not a test or diagnosis. Evaluation and diagnosis are completed by licensed professionals.