

PATIENT'S FORM

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SCREENING OF ANXIETY AND DEPRESSION SYMPTOMS

PATIENT INFORMATION

First Name : Birth Date : (YYYY/MM/DD)

Last Name :

GAD-7 SCALE

Over the last two weeks, how often have you been bothered by the following problems ?	Not at all	Several days	Over half the time	Nearly every day
1. Feeling anxious or on edge.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Not being able to stop or control worrying.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Worrying too much about different things.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Trouble relaxing.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Being so restless that it's hard to sit still.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Become easily annoyed or irritable.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Feeling afraid as if something awful might happen.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Please calculate the total points obtained in this section	Total : <input style="width: 100px;" type="text"/>			

PHQ-9 SCALE

Over the last two weeks, how often have you been bothered by the following problems ?	Not at all	Several days	Over half the time	Nearly every day
1. Little interest or pleasure in doing things.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Feeling tired or having little energy.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Poor appetite or overeating.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or someone else down.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Trouble concentrating on things, such as reading or watching television.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8. Moving or speaking so slowly that other people could have noticed, or the opposite - Being so fidgety/restless that you have been moving around a lot more than usual.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Please calculate the total points obtained in this section	Total : <input style="width: 100px;" type="text"/>			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people ?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: _____ Date Completed: _____

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 your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
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 it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – SELF REPORT (WFIRS-S)

Patient Name: _____ Date: _____ Date of Birth: _____

Work: _____ Full Time _____ Part Time _____ Other: _____

School: _____ Full Time _____ Part Time _____

Circle the number for the rating that best describes how your emotional or behavioural problems have affected each item in the last month.

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
A	FAMILY					
1	Having problems with family					
2	Having problems with spouse/partner					
3	Relying on others to do things for you					
4	Causing fighting in the family					
5	Makes it hard for the family to have fun together					
6	Problems taking care of your family					
7	Problems balancing your needs against those of your family					
8	Problems losing control with family					
B	WORK					
1	Problems performing required duties					
2	Problems with getting your work done efficiently					
3	Problems with your supervisor					
4	Problems keeping a job					
5	Getting fired from work					
6	Problems working in a team					
7	Problems with your attendance					
8	Problems with being late					
9	Problems taking on new tasks					
10	Problems working to your potential					
11	Poor performance evaluations					
C	SCHOOL					
1	Problems taking notes					
2	Problems completing assignments					
3	Problems getting your work done efficiently					
4	Problems with teachers					
5	Problems with school administrators					
6	Problems meeting minimum requirements to stay in school					
7	Problems with attendance					
8	Problems with being late					
9	Problems with working to your potential					
10	Problems with inconsistent grades					
D	LIFE SKILLS					
1	Excessive or inappropriate use of internet, video games or TV					
2	Problems keeping an acceptable appearance					
3	Problems getting ready to leave the house					
4	Problems getting to bed					
5	Problems with nutrition					
6	Problems with sex					

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
7	Problems with sleeping					
8	Getting hurt or injured					
9	Avoiding exercise					
10	Problems keeping regular appointments with doctor/dentist					
11	Problems keeping up with household chores					
12	Problems managing money					
E	SELF-CONCEPT					
1	Feeling bad about yourself					
2	Feeling frustrated with yourself					
3	Feeling discouraged					
4	Not feeling happy with your life					
5	Feeling incompetent					
F	SOCIAL					
1	Getting into arguments					
2	Trouble cooperating					
3	Trouble getting along with people					
4	Problems having fun with other people					
5	Problems participating in hobbies					
6	Problems making friends					
7	Problems keeping friends					
8	Saying inappropriate things					
9	Complaints from neighbours					
G	RISK					
1	Aggressive driving					
2	Doing other things while driving					
3	Road rage					
4	Breaking or damaging things					
5	Doing things that are illegal					
6	Being involved with the police					
7	Smoking cigarettes					
8	Smoking marijuana					
9	Drinking alcohol					
10	Taking "street" drugs					
11	Sex without protection (birth control, condom)					
12	Sexually inappropriate behaviour					
13	Being physically aggressive					
14	Being verbally aggressive					

Number of Items Scored '2' or '3'

Total Score

Mean Score
(N/A items not included in calculation)

A	Family			/
B	Work			/
C	School			/
D	Life Skills			/
E	Self-concept			/
F	Social			/
G	Risky			/
	Total			

A	Family			/
B	Work			/
C	School			/
D	Life Skills			/
E	Self-concept			/
F	Social			/
G	Risky			/
	Total			

A	Family	
B	Work	
C	School	
D	Life Skills	
E	Self-concept	
F	Social	
G	Risky	
	Total	

*Calculated from _____ answered questions.

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WEISS SYMPTOM RECORD II

PATIENT: _____

INFORMANT: _____

DATE: _____

This is a problem checklist. Not all the items will be appropriate for you. Please indicate the level of difficulty associated with each item:

- None:** This is not a problem or concern. Any challenges are age-appropriate
- Mild:** Some difficulty (somewhat)
- Moderate:** This is a problem (pretty much)
- Severe:** This is a serious problem (very much)
- NA:** Not applicable. Check this column if the item is not a problem or not relevant to you.

<i>Difficulty with:</i>	<i>None (0)</i>	<i>Mild (1)</i>	<i>Moderate (2)</i>	<i>Severe (3)</i>	<i>N/A</i>
ATTENTION					
Attention to details or makes careless mistakes					
Holding attention or remaining focused					
Listening or mind seems elsewhere					
Instructions or finishing work					
Organizing (e.g. time, messy, deadlines)					
Avoids or dislikes activities requiring effort					
Loses or misplaces things					
Easily distracted					
Forgetful (e.g. chores, bills, appointments)					
HYPERACTIVITY AND IMPULSIVITY					
Fidgets or squirms					
Trouble staying seated					
Runs about or feels restless inside					
Loud or difficulty being quiet					
Often on the go					
Talks too much					
Blurts out comments					
Dislikes waiting (e.g. taking turns or in line)					
Interrupts or intrudes on others (e.g. butting in)					
OPPOSITIONAL					
Loses temper					
Easily annoyed					
Angry and resentful					
Argues					
Defiant					
Deliberately annoys other people					
Blames other people rather than themselves					
Spiteful					

WEISS SYMPTOM RECORD II

<i>Difficulty with:</i>	<i>None (0)</i>	<i>Mild (1)</i>	<i>Moderate (2)</i>	<i>Severe (3)</i>	<i>N/A</i>
DEVELOPMENT AND LEARNING					
Wetting, (after age 5)					
Soiling (after age 4)					
Reading					
Spelling					
Math					
Writing					
AUTISM SPECTRUM					
Difficulty with talking back and forth					
Unusual eye contact or body language					
Speech is odd (monotone, unusual words)					
Restricted, fixed, intense interests					
Odd, repetitive movements (e.g. flapping)					
Does not easily "chit chat"					
MOTOR DISORDERS					
Repetitive noises (e.g. sniffing, throat clearing)					
Repetitive movements (blinking, shrugging)					
Clumsy					
PSYCHOSIS					
Hearing voices that are not there					
Seeing things that are not there					
Scrambled thinking					
Paranoia (feeling people are against you)					
DEPRESSION					
Sad or depressed most of the day					
Lack of interest or pleasure most of the day					
Weight loss, weight gain or change in appetite					
Difficulty sleeping or sleeping too much					
Agitated					
Slowed down					
Feels worthless					
Tired, no energy					
Hopeless, pessimistic					
Withdrawal from usual interests/people					
Decrease in concentration					

WEISS SYMPTOM RECORD II

<i>Difficulty with:</i>	<i>None (0)</i>	<i>Mild (1)</i>	<i>Moderate (2)</i>	<i>Severe (3)</i>	<i>N/A</i>
MOOD REGULATION					
Distinct period(s) of intense excitement					
Distinct period(s) of inflated self-esteem, grandiose					
Distinct period(s) of increased energy					
Distinct period(s) of decreased need for sleep					
Distinct Period(s) of racing thoughts or speech					
Irritable behaviour that is out of character					
Rage attacks, anger outbursts, hostility					
SUICIDE					
Suicidal thoughts					
Suicide attempt(s) or a plan					
ANXIETY					
Intense fears (e.g. heights, crowds, spiders)					
Fear of social situations or performing					
Panic attacks					
Fear of leaving e.g. the house, public transportation.					
Worrying and/or anxious most days					
Nervous, can't relax					
Obsessive thoughts (e.g. germs, perfectionism)					
Compulsive rituals (e.g. checking, hand washing)					
Hair pulling, nail biting or skin picking					
Preoccupation with physical complaints					
Chronic pain					
STRESS RELATED DISORDERS					
Physical abuse					
Sexual abuse					
Neglect					
Other severe trauma					
PTSD					
Flashbacks or nightmares					
Avoidance					
Intrusive thoughts of traumatic events					

WEISS SYMPTOM RECORD II

<i>Difficulty with:</i>	<i>None (0)</i>	<i>Mild (1)</i>	<i>Moderate (2)</i>	<i>Severe (3)</i>	<i>N/A</i>
SLEEP					
Trouble falling asleep or staying asleep					
Excessive daytime sleepiness					
Snoring or stops breathing during sleep					
EATING					
Distorted body image					
Underweight					
Binge eating					
Overweight					
Eating too little or refusing to eat					
CONDUCT					
Verbal aggression					
Physical aggression					
Used a weapon against people (stones, sticks etc.)					
Cruel to animals					
Physically cruel to people					
Stealing or shoplifting					
Deliberately sets fires					
Deliberately destroys property					
Frequent lying					
Lack of remorse or guilt					
Lack of empathy or concern for others					
SUBSTANCE USE					
Misuse of prescription drugs					
Alcohol > 14 drinks/week or 4 drinks at once					
Smoking or tobacco use					
Marijuana					
Other street drugs					
Excessive over the counter medications					
Excessive caffeine (colas, coffee, tea, pills)					

WEISS SYMPTOM RECORD II

<i>Difficulty with:</i>	<i>None (0)</i>	<i>Mild (1)</i>	<i>Moderate (2)</i>	<i>Severe (3)</i>	<i>N/A</i>
ADDICTIONS					
Gambling					
Excessive internet, gaming or screen time					
Other addiction _____					
PERSONALITY					
Self-destructive					
Stormy, conflicted relationships					
Self-injurious behaviour (e.g. cutting)					
Low self-esteem					
Manipulative					
Self-centered					
Arrogant					
Suspicious					
Deceitful with no remorse					
Breaking the law or antisocial behaviour					
Tends to be a loner					
OTHER (Please indicate any other difficulties)					

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