

ADULT ADHD FORM

PATIENT INFORMATION

Patient's Name: _____ SS# _____ - _____ - _____ Sex: Male Female
Date of Birth: _____ Age: _____ Marital Status: Single Married Separated Divorced Widowed
Home Address: _____
Home Phone: (_____) _____ Occupation: _____ Student
Employer (School, if student): _____ Work/School Phone: (_____) _____
Employer/School Address: _____
E-mail Address: _____ Fax Phone: (_____) _____

RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Party: _____ Date of Birth: _____
Home Address: _____
Home Phone: (_____) _____ Occupation: _____
Employer: _____ Work Phone: (_____) _____
Employer Address: _____
Marital Status: Single Married Separated Divorced Widowed
Spouse's Name: _____ Date of Birth: _____
Spouse's Employer: _____ Address: _____

Please complete this document as accurately as possible and remember all the information provided will be included in the final report which will be forwarded to you and the referring physician. There is a one time fee adults are required to pay at the first appointment. This fee will cover extensive psychometric tools used by the clinic to determine diagnosis and are not covered by the OHIP.

APPOINTMENT CANCELLATION POLICY: ADHD Clinic requires that cancellations for scheduled appointments be received 48 hours in advance during regular office hours (Monday through Friday 9am to 5:00pm. We will give you a courtesy call 24 hours prior to your visit. However we want you to understand that this is courtesy call only. It is not the clinics responsibility to remind you of your appointment. Missed or cancelled appointments that do not follow this policy will be charged the regular OHIP fee and the 120 dollar intake fee at the discretion of your doctor. This fee can be equal but will not exceed the OHIP Billing rate. OHIP does not pay for missed appointment fees and the patient/responsible party is held fully accountable for this charge.

I have read and understand the above stated policies of ADHD Clinic.

Signature of Responsible Party (required): _____

MEDICAL HISTORY

Current medical problems/medications: _____

Current supplement/vitamins/herbs: _____

Past medical problems/medications: _____

Other doctors/clinics seen regularly: _____

Any history of head trauma? (describe): _____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc: _____

Allergies/drug intolerances (describe): _____

Present Height _____ Present Weight _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) _____

Prenatal and birth events: Your parents attitude toward their pregnancy with you _____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc) _____

Any birth problems, trauma, forceps or complications?: _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

School History: Last grade completed _____ Last school attended _____

Average grades received _____ Specific learning disabilities _____

Learning strengths _____

Any behavior problems in school? _____

What have teachers said about you _____

Please bring school report cards and any state, national or special testing that has been performed.

Employment History: (summarize jobs you've had, list most favorite and least favorite)

Any work-related problems? _____

What would your employers or supervisors say about you? _____

Military History? _____

Ever Any Legal Problems? _____

Sexual history: (answer only as much as you feel comfortable)

Age at the time of first sexual experience: _____ Number of sexual partners: _____

Any history of sexually transmitted disease? _____ History of abortion? _____

History of sexual abuse, molestation or rape? _____

Current sexual problems? _____

Name: _____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. _____

Ever experience withdrawal symptoms from alcohol or drugs? _____

Has anyone told you they thought you had a problem with drugs or alcohol? _____

Have you ever felt guilty about your drug or alcohol use? _____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____

Have you ever used drugs or alcohol first thing in the morning? _____

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

Current Marital or Relationship Satisfaction _____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.) _____

History of Past Marriages _____

Natural Mother's History: age _____ outside work _____

School: highest grade completed _____

Learning problems _____ Behavior problems _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Mother's alcohol/drug use history _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

Name: _____

Natural Father's History: age _____ outside work _____

School: highest grade completed _____

Learning problems _____ Behavior problems _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Father's alcohol/drug use history _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

Siblings (names, ages, problems, strengths, relationship to patient) _____

Children (names, ages, problems, strengths) _____

Cultural/Ethnic Background _____

Describe your relationships with friends _____

Describe yourself _____

Describe your strengths _____

Adult General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other person _____

0 1 2 3 4 NA
 Never Rarely Occasionally Frequently Very Frequently Not Applicable/Not Known

Other Self

- ___ ___ 1. depressed or sad mood
- ___ ___ 2. decreased interest in things that are usually fun, including sex
- ___ ___ 3. significant weight gain or loss, or marked appetite changes, increased or decreased
- ___ ___ 4. recurrent thoughts of death or suicide
- ___ ___ 5. sleep changes, lack of sleep or marked increase in sleep
- ___ ___ 6. physically agitated or "slowed down"
- ___ ___ 7. low energy or feelings of tiredness
- ___ ___ 8. feelings of worthlessness, helplessness, hopelessness or guilt
- ___ ___ 9. decreased concentration or memory
- ___ ___ 10. periods of an elevated, high or irritable mood
- ___ ___ 11. periods of a very high self esteem or grandiose thinking
- ___ ___ 12. periods of decreased need for sleep without feeling tired
- ___ ___ 13. more talkative than usual or pressure to keep talking
- ___ ___ 14. racing thoughts or frequent jumping from one subject to another
- ___ ___ 15. easily distracted by irrelevant things
- ___ ___ 16. marked increase in activity level
- ___ ___ 17. excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)
- ___ ___ 18. panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ___)
- ___ ___ 19. periods of trouble breathing or feeling smothered
- ___ ___ 20. periods of feeling dizzy, faint or unsteady on your feet
- ___ ___ 21. periods of heart pounding or rapid heart rate
- ___ ___ 22. periods of trembling or shaking
- ___ ___ 23. periods of sweating
- ___ ___ 24. periods of choking
- ___ ___ 25. periods of nausea or abdominal upset
- ___ ___ 26. feelings of a situation "not being real"
- ___ ___ 27. numbness or tingling sensations
- ___ ___ 28. hot or cold flashes
- ___ ___ 29. periods of chest pain or discomfort
- ___ ___ 30. fear of dying
- ___ ___ 31. fear of going crazy or doing something uncontrolled
- ___ ___ 32. avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable
- ___ ___ 33. excessive fear of being judged by others which causes you to avoid or get anxious in situations
- ___ ___ 34. persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____
- ___ ___ 35. recurrent bothersome thoughts, ideas or images which you try to ignore
- ___ ___ 36. trouble getting "stuck" on certain thoughts, or having the same thought over and over
- ___ ___ 37. excessive or senseless worrying
- ___ ___ 38. others complain that you worry too much or get "stuck" on the same thoughts
- ___ ___ 39. compulsive behaviors that you must do or you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling
- ___ ___ 40. needing to have things done a certain way or you become very upset
- ___ ___ 41. others complain that you do the same thing over and over to an excessive degree (such as cleaning or

checking)

- ___ 42. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.) please list _____
- ___ 43. recurrent distressing dreams of a past upsetting event
- ___ 44. a sense of reliving a past upsetting event
- ___ 45. a sense of panic or fear to events that resemble an upsetting past event
- ___ 46. you spend effort avoiding thoughts or feelings associated with a past trauma
- ___ 47. persistent avoidance of activities/situations which cause remembrance of upsetting event
- ___ 48. inability to recall an important aspect of a past upsetting event
- ___ 49. marked decreased interest in important activities
- ___ 50. feeling detached or distant from others
- ___ 51. feeling numb or restricted in your feelings
- ___ 52. feeling that your future is shortened
- ___ 53. quick startle
- ___ 54. feels like you're always watching for bad things to happen
- ___ 55. marked physical response to events that remind you of a past upsetting event, i.e., sweating when getting in a car if you had been in a car accident
- ___ 56. marked irritability or anger outbursts
- ___ 57. unrealistic or excessive worry in at least a couple areas of your life
- ___ 58. trembling, twitching or feeling shaky
- ___ 59. muscle tension, aches or soreness
- ___ 60. feelings of restlessness
- ___ 61. easily fatigued
- ___ 62. shortness of breath or feeling smothered
- ___ 63. heart pounding or racing
- ___ 64. sweating or cold clammy hands
- ___ 65. dry mouth
- ___ 66. dizziness or lightheadedness
- ___ 67. nausea, diarrhea or other abdominal distress
- ___ 68. hot or cold flashes
- ___ 69. frequent urination
- ___ 70. trouble swallowing or "lump in throat"
- ___ 71. feeling keyed up or on edge
- ___ 72. quick startle response or feeling jumpy
- ___ 73. difficult concentrating or "mind going blank"
- ___ 74. trouble falling or staying asleep
- ___ 75. irritability
- ___ 76. trouble sustaining attention or being easily distracted
- ___ 77. difficulty completing projects
- ___ 78. feeling overwhelmed of the tasks of everyday living
- ___ 79. trouble maintaining an organized work or living area
- ___ 80. inconsistent work performance
- ___ 81. lacks attention to detail
- ___ 82. makes decisions impulsively
- ___ 83. difficulty delaying what you want, having to have your needs met immediately
- ___ 84. restless, fidgety
- ___ 85. make comments to others without considering their impact
- ___ 86. impatient, easily frustrated
- ___ 87. frequent traffic violations or near accidents
- ___ 88. refusal to maintain body weight above a level most people consider healthy
- ___ 89. intense fear of gaining weight or becoming fat even though underweight
- ___ 90. feelings of being fat, even though you're underweight
- ___ 91. recurrent episodes of binge eating large amounts of food
- ___ 92. a feeling of lack of control over eating behavior
- ___ 93. engage in regular activities to purge binges, such as self induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise
- ___ 94. persistent overconcern with body shape and weight
- ___ 95a. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head

- _____ jerking or picking). How long have motor tics been present?_____ How often?_____ describe_____
- _____ 95b. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing). How long have verbal tics been present?_____ How often?_____ describe_____
- _____ 96. delusional or bizarre thoughts (thoughts you know others would think are false)
- _____ 97. seeing objects, shadows or movements that are not real
- _____ 98. hearing voices or sounds that are not real
- _____ 99. periods of time where your thoughts or speech were disjointed or didn't make sense to you or others
- _____ 100. social isolation or withdrawal
- _____ 101. severely impaired ability to function at home or at work
- _____ 102. peculiar behaviors
- _____ 103. lack of personal hygiene or grooming
- _____ 104. inappropriate mood for the situation (i.e., laughing at sad events)
- _____ 105. marked lack of initiative
- _____ 106. frequent feelings that someone or something is out to hurt you or discredit you
- _____ 107. do you snore loudly (or do others complain about your snoring)
- _____ 108. have others said you stop breathing when you sleep
- _____ 109. do you feel fatigued or tired during the day
- _____ 110. do you often feel cold when others feel fine or they are warm
- _____ 111. do you often feel warm when others feel fine or they are cold
- _____ 112. do you have problems with brittle or dry hair
- _____ 113. do you have problems with dry skin
- _____ 114. do you have problems with sweating
- _____ 115. do you have problems with chronic anxiety or tension
- _____ 116. impairment in communication as manifested by at least one of the following:
- delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - repetitive use of language or odd language
 - lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
- _____ 117. impairment in social interaction, with at least two of the following:
- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - lack of social or emotional reciprocity
- _____ 118. repetitive patterns of behavior, interests, and activities, as manifested by at least one of following:
- preoccupation with an area of that is abnormal either in intensity or focus
 - rigid adherence to specific, nonfunctional routines or rituals
 - repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - persistent preoccupation with parts of objects

Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other Self

- | | | |
|-------|-----|--|
| _____ | ___ | 1. Fails to give close attention to details or makes careless mistakes |
| _____ | ___ | 2. Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork) |
| _____ | ___ | 3. Trouble listening |
| _____ | ___ | 4. Fails to finish things |
| _____ | ___ | 5. Poor organization for time or space (such as backpack, room, desk, paperwork) |
| _____ | ___ | 6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort |
| _____ | ___ | 7. Loses things |
| _____ | ___ | 8. Easily distracted |
| _____ | ___ | 9. Forgetful |
| _____ | ___ | 10. Poor planning skills |
| _____ | ___ | 11. Lack clear goals or forward thinking |
| _____ | ___ | 12. Difficulty expressing feelings |
| _____ | ___ | 13. Difficulty expressing empathy for others |
| _____ | ___ | 14. Excessive daydreaming |
| _____ | ___ | 15. Feeling bored |
| _____ | ___ | 16. Feeling apathetic or unmotivated |
| _____ | ___ | 17. Feeling tired, sluggish or slow moving |
| _____ | ___ | 18. Feeling spacey or "in a fog" |
| _____ | ___ | 19. Fidgety, restless or trouble sitting still |
| _____ | ___ | 20. Difficulty remaining seated in situations where remaining seated is expected |
| _____ | ___ | 21. Runs about or climbs excessively in situations in which it is inappropriate |
| _____ | ___ | 22. Difficulty playing quietly |
| _____ | ___ | 23. "On the go" or acts as if "driven by a motor" |
| _____ | ___ | 24. Talks excessively |
| _____ | ___ | 25. Blurts out answers before questions have been completed |
| _____ | ___ | 26. Difficulty waiting turn |
| _____ | ___ | 27. Interrupts or intrudes on others (e.g., butts into conversations or games) |
| _____ | ___ | 28. Impulsive (saying or doing things without thinking first) |
| _____ | ___ | 29. Excessive or senseless worrying |
| _____ | ___ | 30. Upset when things do not go your way |
| _____ | ___ | 31. Upset when things are out of place |
| _____ | ___ | 32. Tendency to be oppositional or argumentative |
| _____ | ___ | 33. Tendency to have repetitive negative thoughts |
| _____ | ___ | 34. Tendency toward compulsive behaviors |
| _____ | ___ | 35. Intense dislike for change |
| _____ | ___ | 36. Tendency to hold grudges |
| _____ | ___ | 37. Trouble shifting attention from subject to subject |
| _____ | ___ | 38. Trouble shifting behavior from task to task |
| _____ | ___ | 39. Difficulties seeing options in situations |
| _____ | ___ | 40. Tendency to hold on to own opinion and not listen to others |
| _____ | ___ | 41. Tendency to get locked into a course of action, whether or not it is good |
| _____ | ___ | 42. Needing to have things done a certain way or you become very upset |
| _____ | ___ | 43. Others complain that you worry too much |
| _____ | ___ | 44. Tend to say no without first thinking about question |
| _____ | ___ | 45. Tendency to predict fear |
| _____ | ___ | 46. Frequent feelings of sadness |
| _____ | ___ | 47. Moodiness |
| _____ | ___ | 48. Negativity |

- ___ 49. Low energy
- ___ 50. Irritability
- ___ 51. Decreased interest in others
- ___ 52. Decreased interest in things that are usually fun or pleasurable
- ___ 53. Feelings of hopelessness about the future
- ___ 54. Feelings of helplessness or powerlessness
- ___ 55. Feeling dissatisfied or bored
- ___ 56. Excessive guilt
- ___ 57. Suicidal feelings
- ___ 58. Crying spells
- ___ 59. Lowered interest in things usually considered fun
- ___ 60. Sleep changes (too much or too little)
- ___ 61. Appetite changes (too much or too little)
- ___ 62. Chronic low self-esteem
- ___ 63. Negative sensitivity to smells/odors
- ___ 64. Frequent feelings of nervousness or anxiety
- ___ 65. Panic attacks
- ___ 66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
- ___ 67. Periods of heart pounding, rapid heart rate or chest pain
- ___ 68. Periods of trouble breathing or feeling smothered
- ___ 69. Periods of feeling dizzy, faint or unsteady on your feet
- ___ 70. Periods of nausea or abdominal upset
- ___ 71. Periods of sweating, hot or cold flashes
- ___ 72. Tendency to predict the worst
- ___ 73. Fear of dying or doing something crazy
- ___ 74. Avoid places for fear of having an anxiety attack
- ___ 75. Conflict avoidance
- ___ 76. Excessive fear of being judged or scrutinized by others
- ___ 77. Persistent phobias
- ___ 78. Low motivation
- ___ 79. Excessive motivation
- ___ 80. Tics (motor or vocal)
- ___ 81. Poor handwriting
- ___ 82. Quick startle
- ___ 83. Tendency to freeze in anxiety provoking situations
- ___ 84. Lacks confidence in their abilities
- ___ 85. Seems shy or timid
- ___ 86. Easily embarrassed
- ___ 87. Sensitive to criticism
- ___ 88. Bites fingernails or picks skin
- ___ 89. Short fuse or periods of extreme irritability
- ___ 90. Periods of rage with little provocation
- ___ 91. Often misinterprets comments as negative when they are not
- ___ 92. Irritability tends to build, then explodes, then recedes, often tired after a rage
- ___ 93. Periods of spaciness or confusion
- ___ 94. Periods of panic and/or fear for no specific reason
- ___ 95. Visual or auditory changes, such as seeing shadows or hearing muffled sounds
- ___ 96. Frequent periods of deja vu (feelings of being somewhere you have never been)
- ___ 97. Sensitivity or mild paranoia
- ___ 98. Headaches or abdominal pain of uncertain origin
- ___ 99. History of a head injury or family history of violence or explosiveness
- ___ 100. Dark thoughts, may involve suicidal or homicidal thoughts
- ___ 101. Periods of forgetfulness or memory problems

Learning Disability Screening Questionnaire

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person (such as a spouse, partner or parent) rate you as well. List other person _____

0 1 2 3 4 NA
Never Rarely Occasionally Frequently Very Frequently Not Applicable/Not Known

Other Self

Reading

- ___ ___ 1. I am a poor reader.
___ ___ 2. I do not like reading.
___ ___ 3. I make mistakes when reading like skipping words or lines.
___ ___ 4. I read the same line twice.
___ ___ 5. I have problems remembering what I read even though I have read all the words.
___ ___ 6. I reverse letters when I read (such as b/d, p/q).
___ ___ 7. I switch letters in words when reading (such as god and dog).
___ ___ 8. My eyes hurt or water when I read.
___ ___ 9. Words tend to blur when I read.
___ ___ 10. Words tend to move around the page when I read.
___ ___ 11. When reading I have difficulty understanding the main idea or identifying important details.

Writing

- ___ ___ 12. I have "messy" handwriting.
___ ___ 13. My work tends to be messy.
___ ___ 14. I prefer print rather than writing in cursive.
___ ___ 15. My letters run into each other or there is no space between words.
___ ___ 16. I have trouble staying within lines.
___ ___ 17. I have problems with grammar or punctuation.
___ ___ 18. I am a poor speller.
___ ___ 19. I have trouble copying off the board or from a page in a book.
___ ___ 20. I have trouble getting thoughts from my brain to the paper.
___ ___ 21. I can tell a story but cannot write it.

Body Awareness/ Spatial Relationships

- ___ ___ 22. I have trouble with knowing my left from my right.
___ ___ 23. I have trouble keeping things within columns or coloring within lines.
___ ___ 24. I tend to be clumsy, uncoordinated.
___ ___ 25. I have difficulty with eye hand coordination.
___ ___ 26. I have difficulty with concepts such as up, down, over or under.
___ ___ 27. I tend to bump into things when walking.

Oral Expressive language

- ___ ___ 28. I have difficulty expressing myself in words.
___ ___ 29. I have trouble finding the right word to say in conversations.
___ ___ 30. I have trouble talking around a subject or getting to the point in conversations.

Receptive language

- ___ ___ 31. I have trouble keeping up or understanding what is being said in conversations.
___ ___ 32. I tend to misunderstand people and give the wrong answers in conversations.
___ ___ 33. I have trouble understanding directions people tell me.

- ___ ___ 34. I have trouble telling the direction sound is coming from.
___ ___ 35. I have trouble filtering out background noises.

Math

- ___ ___ 36. I am poor at basic math skills for my age (adding, subtracting, multiplying and dividing)
___ ___ 37. I makes “careless mistakes” in math.
___ ___ 38. I tend to switch numbers around.
___ ___ 39. I have difficulty with word problems.

Sequencing

- ___ ___ 40. I have trouble getting everything in the right order when I speak.
___ ___ 41. I have trouble telling time.
___ ___ 42. I have trouble using the alphabet in order.
___ ___ 43. I have trouble saying the months of the year in order.

Abstraction

- ___ ___ 44. I have trouble understanding jokes people tell me.
___ ___ 45. I tend to take things too literally.

Organization

- ___ ___ 46. My notebook/paperwork is messy or disorganized.
___ ___ 47. My room is messy.
___ ___ 48. I tend to shove everything into my backpack, desk or closet.
___ ___ 49. I have multiple piles around my room.
___ ___ 50. I have trouble planning my time.
___ ___ 51. I am frequently late or in a hurry.
___ ___ 52. I often do not write down assignments or tasks and end up forgetting what to do.

Memory

- ___ ___ 53. I have trouble with my memory.
___ ___ 54. I remember things from long ago but not recent events.
___ ___ 55. It is hard for me to memorize things for school or work.
___ ___ 56. I know something one day but do not remember it to the next.
___ ___ 57. I forget what I am going to say right in the middle of saying it.
___ ___ 58. I have trouble following directions that have more than one or two steps.

Social Skills

- ___ ___ 59. I have few or no friends.
___ ___ 60. I have trouble reading body language or facial expressions of others.
___ ___ 61. My feelings are often or easily hurt.
___ ___ 62. I tend to get into trouble with friends, teachers, parents or bosses.
___ ___ 63. I feel uncomfortable around people I do not know well.
___ ___ 64. I am teased by others.
___ ___ 65. Friends do not call and ask me to do things with them.
___ ___ 66. I do not get together with others outside of school or work.

Scotopic Sensitivity

- ___ ___ 67. I am light sensitive. Bothered by glare, sunlight, headlights or streetlights.
___ ___ 68. I become tired, experience headaches, mood changes, feel restless or an inability to stay focused with bright or fluorescent lights.
___ ___ 69. I have trouble reading words that are on white, glossy paper.
___ ___ 70. When reading words or letters shift, shake, blur, move, run together, disappear or become difficult to perceive.
___ ___ 71. I feel tense, tired, sleepy, or even get headaches with reading
___ ___ 72. I have problems judging distance and have difficulty with such things as escalators, stairs, ball sports, or driving..

Sensory Integration Issues

- 73. I seem to be more sensitive to the environment than others.
- 74. I am more sensitive to noise than others.
- 75. I am particularly sensitive to touch or very sensitive to certain clothing or tags on the clothing.
- 76. I have unusual sensitivity to certain smells.
- 77. I have unusual sensitivity to light.
- 78. I am sensitive to movement or crave spinning activities?
- 79. I tend to be clumsy or accident-prone.

