COLUMBIA HEALTH
Counseling & Psychological Services

Student ADHD Questionnaire

Please complete this form before your initial assessment and send via secure message on the Patient Portal to expedite the evaluation process. You may also bring hard copies to your initial appointment.

Student Name:			Date:
Date of birth:	UNI:	Pronouns:	
Name/ location of your high school:		Year graduated:	GPA:
How many years have you attended Columbia University?			Current GPA:
Current academic standing: ☐ 1st year ☐ SO ☐ JR ☐ SR ☐ Graduate student ☐ Other			
Current major/ degree program:		How many times have you changed majors?	
Address during academic year: ☐ dorm ☐ sorority/ fraternity house ☐ on-campus housing ☐ off-campus housing ☐ other (describe):			
Reason for this evaluation: Please list the symptoms and impairments that led you to seek an ADHD evaluation, including concerns expressed by others (professors, roommates, parents, and other significant adults in your life). If you have previously been diagnosed with ADHD, list your current most impairing symptoms off medication.			
Have you ever been diagnosed with ADHD? ☐ No ☐ Yes			
If yes: How old were you?			
Which type? ☐ inattentive predominant ☐ hyperactive-impulsive predominant ☐ combined			
Who made the diagnosis? ☐ Psychologist ☐ Pediatrician ☐ Family MD ☐ Psychiatrist ☐ Other:			
Which of the following were involved in making the diagnosis? ☐ Clinical interview and observation ☐ Checklists by you ☐ Checklists by parents ☐ Checklists by teachers ☐ Psycho-educational testing ☐ Computerized testing ☐ Other (specify):			
Have you ever been diagnosed with a learning disability? ☐ No ☐ Yes			
If yes, please describe:			

Please check the following items that were true for you **most or all of the time** during each period:

	Elementary School	Middle School	High School
Blurted out answers before the questions have been completed			
Did not sustain attention to schoolwork during classes			
Talked excessively			
Had trouble playing or doing leisure things quietly			
Acted or spoke without thinking			
Fidgeted or got out of seat excessively			
Did not give close attention to details, made careless mistakes			

	Elementary School	Middle School	High School
Required disciplinary interventions, e.g. sat in front of the class			
Had trouble organizing activities			
Had problems with peers, e.g. difficulty waiting for turn			
Frequently lost things for tasks or activities, e.g. books, assignments			
Did not appear to be listening when spoken to			
Failed to finish schoolwork and chores			
Did just enough to get by			

Describe details/ examples of checked items in Elementary School:

Describe details/ examples of checked items in Middle School:

Describe details/ examples of checked items in High School:

Medical History

Current medical illness(es), if any:

Current medication(s), if any:

History of thyroid disease? ☐ No ☐ Yes ☐ Not sure

History of head injury (with or without loss of consciousness)? ☐ No ☐ Yes ☐ Not Sure

Current sleep disorder? ☐ No ☐ Yes ☐ Not sure

- Trouble falling asleep? ☐ No ☐ Yes ☐ Not sure
- Difficulty staying asleep? ☐ No ☐ Yes ☐ Not sure
- Disrupted breathing or loud snoring during sleep? ☐ No ☐ Yes ☐ Not sure
- Dozing off during the day? ☐ No ☐ Yes ☐ Not sure
- Average amount of time before falling asleep (minutes):
- Average number of hours of sleep per night:

History of heart disease (palpitations, murmurs, congenital heart disease)? ☐ No ☐ Yes ☐ Not sure

If yes, please describe:

- Have you ever fainted? ☐ No ☐ Yes ☐ Not sure
  If yes, please describe circumstances:

- Any family history of heart disease? ☐No ☐Yes ☐Not sure
  If yes, please describe:

- Have any family member died from heart disease before the age of 50?
  ☐No ☐Yes ☐Not sure
  If yes, please describe circumstances:

Any family history of ADHD? ☐No ☐Yes ☐Not sure

If yes, please describe:

Any family history of learning disabilities? ☐No ☐Yes ☐Not sure

If yes, please describe:

Please list the medications you are currently taking or have taken most recently for ADHD, if any:

Name of medication/ maximum dose	Age started	Duration (months/ years)	Was it effective?	Side effects, if any	If not longer taking, why did you stop?

Other past psychiatric history

Have you ever been diagnosed with any of the following mental health conditions?

- Depression ☐No ☐Yes ☐Not sure
  If yes, please describe:

- Anxiety disorder ☐No ☐Yes ☐Not sure
  If yes, please describe:

- Bipolar disorder ☐ No ☐ Yes ☐ Not sure
  If yes, please describe:

- Other (specify):

Which emotional / behavioral health medications (like antidepressants, mood stabilizers), if any, have been prescribed for you?

Name of medication/ maximum dose	Age started	Duration (months/ years)	Was it effective?	Side effects, if any	If not longer taking, why did you stop?

History of alcohol and drug use:			
	No	Yes	If yes, please describe usage, e.g. frequency, age started, if you have been treated for usage etc.
Caffeine			
Nicotine			
Alcohol			
Marijuana			
Cocaine			
Ecstasy			
Opioids			
Hallucinogens			
Prescription medications			
Other (specify):			

Driving/ Legal History
How many motor vehicle accidents, if any, have you been involved with as a driver?
In how many of these were you “at fault?”
How many of these resulted from being distracted?
How many traffic tickets (not including parking tickets) have you received?
How many parking tickets?
Has your driver’s license ever been suspended? ☐ No ☐ Yes ☐ Not sure
If applicable, # of DUI/ DWI citations:
Have you had any legal problems other than the above? ☐ No ☐ Yes ☐ Not sure
If yes, please describe and give date/ age you were at the time:

Thank you for completing this questionnaire.

In order to expedite your evaluation, please send this completed questionnaire to CPS via secure message on the Patient Portal.