ADHD Adult Diagnostic Intake Form

Personal Information

Full Name

Date of Birth

Preferred Pronouns

Phone Number

Email Address

Address

Reason for Referral

Please describe your main concern(s)

Current Symptoms

Which ADHD symptoms are you experiencing?

Duration of Symptoms

Medical History

Do you have any current or past medical conditions?

Current Medications

Mental Health History

Previous Mental Health Diagnoses

Previous Counseling or Therapy

Family & Developmental History

Were there developmental, learning, or behavioral problems in childhood?

Family history of ADHD or mental health conditions?

Educational/Occupational History

Education Level

Current Occupation/Employment Status

Academic or work-related difficulties

Substance Use

Do you currently use or have you used any substances (alcohol, tobacco, drugs)?

Additional Information

Is there anything else you would like to mention?