PLEASE RETURN FORMS BY:
EMAIL: Cal.Bar@ahs.ca or FAX: (403) 955-8634 or MAIL: 1820 Richmond Rd SW, Calgary, AB, T2T 5C7

Alberta Health Services

Date: _____

Name: _____
Date of birth: _____
Healthcare #: _____

ADHD Screening					
Answer the questions below, rating yourself on each of the criteria using the scale on the right side of the page. Mark the box that best describes how you have felt and conducted yourself over the past 6 months.	**Never**	**Rarely**	**Sometimes**	**Often**	**Very Often**
1. How often do you have trouble wrapping up the final details of a project?	☐	☐	☐	☐	☐
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐