



(Accredited by American Academy of Sleep Medicine)

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### Attention Deficit Rating Scale

If this is the first time you are filling this out at this office, answer keeping in mind the last six months. Mark symptoms present only if they have been present for at least six months. If you have filled out this questionnaire before at this office, answer based on the period of time since you last filled this out. Be sure to answer every question to the best of your ability.

A.	Never	Sometimes	Often	Frequent
1. Fail to pay close attention to details, or makes careless mistakes in schoolwork, work or other activities	0: _____	1: _____	2: _____	3: _____
<b>2. Difficulty sustaining attention in tasks or play activities</b>	0: _____	1: _____	2: _____	3: _____
3. Not seeming to listen when spoken to directly	0: _____	1: _____	2: _____	3: _____
<b>4. Not follow through on instructions and fail to finish schoolwork, chores, or duties at work</b>	0: _____	1: _____	2: _____	3: _____
5. Difficulty organizing tasks and activities	0: _____	1: _____	2: _____	3: _____
<b>6. Avoid, dislike or reluctant to do tasks that require sustained mental effort</b>	0: _____	1: _____	2: _____	3: _____
7. Lose things necessary for tasks or activities	0: _____	1: _____	2: _____	3: _____
<b>8. Easily distracted by extraneous stimuli</b>	0: _____	1: _____	2: _____	3: _____
9. Forgetful in daily activities	0: _____	1: _____	2: _____	3: _____
B.	Never	Sometimes	Often	Frequent
1. Fidget with or tap hands or feet or squirm in seat	0: _____	1: _____	2: _____	3: _____
<b>2. Leave seat in situations where remaining seated is expected</b>	0: _____	1: _____	2: _____	3: _____
3. Run about or climb excessively in situations where it is inappropriate (in adults, may be limited to feeling restless)	0: _____	1: _____	2: _____	3: _____
<b>4. Unable to play or engage in leisure activities quietly</b>	0: _____	1: _____	2: _____	3: _____
5. "On the go", acting as if "driven by a motor"	0: _____	1: _____	2: _____	3: _____
<b>6. Talk excessively</b>	0: _____	1: _____	2: _____	3: _____
7. Blur out an answer before a question has been completed	0: _____	1: _____	2: _____	3: _____
<b>8. Difficulty waiting turn</b>	0: _____	1: _____	2: _____	3: _____
9. Interrupt or intrude on others	0: _____	1: _____	2: _____	3: _____
C.	Never	Sometimes	Often	Frequent
1. Do symptoms rated above cause significant impairment or distress at home, school or work; with friends or relatives; in other activities	0: _____	1: _____	2: _____	3: _____

**Total: A: \_\_\_\_\_ B: \_\_\_\_\_**

### Please mark any symptoms you currently have:

<b>General</b>		<b>Cardiovascular</b>		<b>Neurological</b>	
Appetite Decrease	: _____	Dizziness	: _____	Drowsiness	: _____
Appetite Increase	: _____	Palpitations	: _____	Difficulty sleeping	: _____
<b>Ear Nose Mouth Throat</b>		<b>Genitourinary</b>		<b>Psychiatric</b>	
Dry mouth	: _____	Difficulty with sexual arousal	: _____	Anxiety	: _____
Nasal congestion	: _____	Difficulty urinating	: _____	Irritability	: _____