TAK Center for Mental Health
1069 Central Street, Leominster MA 01453
Telephone: 978-728-4957
Fax: 978-798-1366
takcmh.com

PSYCHIATRIC & MEDICATION MANAGEMENT NEW PATIENT FORM

We would like to take this opportunity to welcome you to our practice and to thank you for choosing TAK Center for Mental Health for your behavioral health needs.

The goal of these forms is to gather relevant information prior to your appointment, so our providers can review this beforehand and offer customized care during the visit. Upon completion of this paperwork, you may return via DocuSign, mail, email, fax, or come to the office to drop it off. Our team will call to schedule your first appointment once this packet has been completed in its entirety within 48 hours. At times, there may be delays due to unforeseen circumstances, so if you do not hear back from our team, we recommend reaching out to us to expedite the process.

We believe that the foundation to a healthy provider and patient relationship revolves around trust, respect, and communication. As such, a week prior to being seen, we will call to confirm your appointment. It is essential that we receive a confirmation, if we are unable to reach you multiple times prior to your appointment, your appointment may be cancelled to fill in another patient on our wait-list. Please contact us if you miss a call from our clinic so we can keep your files updated. As there is a strong need for behavioral health services and we are reserving an hour slot for your new patient visit, we may elect a $250 rebooking charge if you cancel within 24 hours of your appointment time or you "no-show" your first appointment. This fee would be due before we are able to reschedule your missed appointment.

Prior to your first appointment, please confirm coverage with your health insurance company to verify your benefits and eligibility. They will be able to assist you with what to expect coverage wise, and if there is any financial responsibility (copayment, deductible, co-insurance, etc). When calling your insurance, please advise them you are seeing Dr. Ramteen Rezai, NPI number 1376890590, and would like to confirm coverage and benefits. Our clinic checks to confirm your insurance is active prior to your appointment, and submits the claim to your insurance, so we encourage you to reach out to your insurance beforehand to understand how your specific benefits work.

Please be advised that we are an outpatient behavioral health clinic, and appointments are booked ahead of time; for any urgent needs, we will try our best to service you, however we cannot guarantee any same-day appointments or walk-in appointments. For any medical or psychiatric emergency, please dial 9-1-1 or go to your closest emergency room.

Our office is open Monday to Friday, with operating hours from 8:00AM – 5:30PM Monday to Thursday, and 8:00AM to 4:30PM on Fridays. We are closed during federal holidays. If you have any questions or need help filling out this form, you may reach us via phone, 978-728-4957, email, takcmhinfo@takmedgroup.com, fax, 978-798-1366.

We know how important this visit is to you, and we once again thank you for choosing TAK Center for Mental Health. We look forward to working with you on your journey to well-being and health.

Sincerely,
Your team at TAK Center for Mental Health

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MEDICATION AND COMPLIANCE AGREEMENT

An effective provider-patient rapport is critical for quality health care. For this reason, the following treatment agreement has been developed to facilitate a positive therapeutic relationship. If you are unable to agree to the below conditions, TAK Center for Mental Health will not be able to proceed with establishing care as we may not be the best fit for you, and we encourage you to reach out to your primary care provider or insurance to find additional options.

In signing this form, you adhere to the following policies that are a requirement of electing services:

1. I agree to obtain my psychiatric medication prescriptions from this office only. If there are other providers who are responsible for prescribing behavioral health medication, I will notify Dr. Ramteen Rezai immediately. These medications will be filled at the following pharmacy _____. I understand my pharmacy records may be accessed to verify compliance and prescription needs.
2. I understand that TAK Center for Mental Health has controlled substance dosage thresholds and my provider may request me to taper off or decrease the dosage of a controlled medication if appropriate.
3. I agree to take my medications only as prescribed by my provider at TAK Center for Mental Health. I will not vary the dosage or interval of taking these medications without first discussing it with the care team at TAK Center for Mental Health.
4. I understand that my provider at TAK Center for Mental Health will only provide refills of my prescriptions during standard operating hours. I understand it is my responsibility to know when my medications are about to run out and I should call the office within 72 business hours in advance when requesting a refill.
5. Coordination of care and open communication is important, I will notify my provider if I start a new controlled medication from another office, have substance abuse instances, or become pregnant.
6. Where indicated in select cases and as determined by my provider, I agree to submit to planned and/or unannounced oral, urine, or blood testing in order to properly assess the effects of my medication and compliance. If the results of my testing show that I am positive for illegal drugs, or medication not known by my provider, I may be subject to being discharged from this practice. I understand these lab testing's are done through an outside laboratory, such as LabCorp or Quest Diagnostics, and that I will confirm coverage with my insurance to these tests.
7. I understand that lost or stolen medications may not be refilled under certain circumstances before they are due. It is my responsibility to protect and secure all medications. This includes keeping the medication out of the reach of children. A copy of a police report will be required for any lost or stolen controlled substance medications. I understand my treatment in this office will be discontinued if I give my medication to others, trade, sell, or misuse my medication.
8. I agree to notify this office as soon as possible if any narcotics or other controlled medication are prescribed for me by any other sources (such as emergency departments, dentists, urgent cares, other providers), as certain medication may interfere with psychiatric treatment.

I have read this agreement, understand it, and have had any questions answered to my satisfaction. I agree to the proper use of my medication and agree to comply with the above policies. I understand the failing to keep this agreement may result in my care being terminated. A copy of this agreement will be added to my medical records.

Patient Name: _____ **Date of birth: _____**

Patient/Representative Signature: _____ **Date: _____**

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TERMS AND TREATMENT AGREEMENT

APPOINTMENTS:

It is critical to keep your scheduled appointments, as it effects your care, operations of the office, and patients who could have used the slot. We understand situations happen where you need to move your appointment, we ask that you kindly call the office at least 24 hours in advance. Any patient who arrives 10 minutes late for their appointment will only be seen if the physician's schedule allows, this is up to the discretion of the provider. If the appointment needs to be rescheduled, this will be considered a same-day cancellation.

A pattern of same-day cancellations and no-shows are subject to fees and/or potential termination from the practice. The first same-day cancellation or no-show within a calendar year may result in a $50 charge, second time may result in a $100 charge, and a third time may result in a $150 charge to be due prior to booking. Any additional times may result in discharge from the practice. One-time emergencies will be considered.

For urgent issues, our office will try to make any same-day accommodations, however we cannot guarantee an appointment. For emergencies, please contact your nearest emergency department or contact 9-1-1.

PAYMENTS AND FEES:

Our office accepts major credit cards, checks, and HSA/FSA accounts for your convenience. Due to the COVID-19 pandemic, we are no longer accepting cash. Co-payments are due at the time of the appointment and if any denied claims from your health insurance company will be the patient responsibility. Any patient responsibilities are due to your health insurance coverage and benefits; it is recommended to contact your insurance prior to contacting our office to review any bills. If you are experiencing financial difficulties, we may set up a payment plan for any cost-share responsibilities.

INSURANCE:

TAK Center for Mental Health accepts most insurance health policies, however it is the patient's responsibility to confirm coverage, eligibility, and benefits. If changing insurance carriers or to update your insurance information, please notify our office as soon as possible. If you are self-paying, payment is due at the time the service is rendered.

PERSONAL CONDUCT:

All services at TAK Center of Mental Health are built on a foundation of honesty, respect, and communication. Harassment, disorderly conduct, or verbal abuse to any of our staff is not tolerated and may result in ending the visit and/or discharge from the practice.

CONFIDENTIALITY:

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to specific individuals or parties. However, there are limitations to confidentiality such as in a legal or court proceeding, the release of patient information may be mandated by court order, and in instances where a patient is a threat to serious harm to themselves or someone else, or suspicion that a patient is a perpetrator or observer of physical, emotional, or sexual abuse of children, elderly, or disabled individuals.

Patient Name: _____ **Date of birth: _____**

Patient/Representative Signature: _____ **Date: _____**

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AUTHORIZATION/REQUEST FOR RELEASE of BEHAVORIAL HEALTH RECORD

(Also known as Protected Health Information)

Date: / /
Patient Name _____ Date of Birth _____

Psychotherapy Provider Information:
Deborah Parsons, LMHC *Caryn Stewart, LICSW*

Psychiatric Medication Management Provider Information:
Dr. Ramteen Rezai *Meagan Dembitzky, N.P.* *Kathleen Dalton, N.P.* *Michelle VivoAmore, N.P.*

I, (or on behalf of) _____ give permission to the providers listed above at TAK Center for Mental Health to exchange information about my medical and behavioral health internally amongst each other for applicable coordination of care.

In addition:
I authorize the exchange of information about any substance or alcohol abuse in my medical records.
[ ] Yes [ ] No

I authorize the exchange of information about any HIV blood tests results or HIV- or AIDS- related care in my records:
[ ] Yes [ ] No

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying TAK Center for Mental Health at the address indicated above, in writing, and this authorization will cease to be effective on the date notified unless the information has already been released.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I hereby release all parties stated herewith from any liability resulting from the release of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient: _____ Date: _____
OR
Signature of Authorized Representative: _____ Name, Relationship, Date: _____

Refusal to Release Information
I do not consent to release the information as described above. However, I understand that if I do not allow my providers to exchange information about me, their ability to fully coordinate my care may be limited. I understand that in an emergency situation my providers may exchange information as medically necessary.

Signature of Patient/Representative: _____ Date: _____

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AUTHORIZATION/REQUEST FOR RELEASE of BEHAVORIAL HEALTH RECORD

(Also known as Protected Health Information)

Date: / /
Patient Name _____ Date of Birth _____

External Provider Information:

*Primary care physician, therapist, past specialist, or party that you would like to grant access to exchange information:

Name of Individual/Group/Party: _____

Address: _____

Phone Number: _____ Fax Number: _____

I, (or on behalf of) _____ give permission to the providers at TAK Center for Mental Health to exchange information about my medical and behavioral health records to the above party.

In addition:

I authorize the exchange of information about any substance or alcohol abuse in my medical records.
[ ] Yes [ ] No

I authorize the exchange of information about any HIV blood tests results or HIV- or AIDS- related care in my records:
[ ] Yes [ ] No

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying TAK Center for Mental Health at the address indicated above, in writing, and this authorization will cease to be effective on the date notified unless the information has already been released.
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4. I hereby release all parties stated herewith from any liability resulting from the release of this information.

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OR
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Signature of Patient/Representative: _____ Date: _____

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NEW PATIENT INTAKE QUESTIONNAIRE

Date: / /
Patient Name _____ Date of Birth _____

Who were you referred by? _____

Marital Status: ☐ Married ☐ Single ☐Divorced ☐Widowed ☐Long-Term Relationship

Do you have any children? ☐Yes ☐ No If yes, how many?_____ If yes, ages?_____

Current Living Situation: ☐Apartment/House ☐ Community Residence ☐Supported Housing

☐Shelter ☐Other _____

Do you live Alone? ☐Yes ☐No If no, who lives with you?

Names:	Relationship:
_____	_____
_____	_____
_____	_____

What are your present sources of financial support? (Check all that apply)

☐ Employment ☐ Savings ☐ Disability ☐ Workers Comp ☐Spouse
☐ Parents ☐ Retirement ☐ Investments ☐ Other: _____

Current Problems

Please check all that apply within the last month:

☐ Depressed mood ☐ Decreased motivation or pleasure ☐ Crying ☐ Hopelessness
☐ Suicidal thoughts ☐ Recurrent thoughts of death ☐ Eating changes ☐ Anxiety
☐ Sleep disturbance ☐ Irritability ☐ Anger ☐ Aggression
☐ Panic attacks ☐ Embarrassed easily ☐ Excessive worrying ☐ Intrusive thoughts
☐ Nightmares ☐ Feeling disconnected from self ☐ Extreme energy ☐ Mood swings
☐ Racing thoughts ☐ Hallucinations ☐ Concentration issues ☐ Memory issues
☐ Stressful life events ☐ Feel like people are trying to hurt you

☐ OTHER COMMENTS: _____

_____

_____

Psychiatric History:

Have you ever met with a mental health professional (psychiatrist/psychologist/therapist)?

☐ Yes ☐ No

If so, please provide the following information:

Name & Degree	City	Problem	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been sexually, emotionally, or physically abused by family or anyone else? ☐ Yes ☐ No

Have you ever been hospitalized for a psychiatric problem? ☐ Yes ☐ No

If so, please provide the following information for each hospitalization.

Name of Hospital	City	Reason	Dates
_____	_____	_____	_____
_____	_____	_____	_____

In the past month:

Have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No

Have you had any thoughts of killing yourself? ☐ Yes ☐ No

Have you been thinking about or planning on how you might kill yourself? ☐ Yes ☐ No

Have you had any intention of acting on your thoughts or carrying out your plan? ☐ Yes ☐ No

In the past (anytime):

Have you ever attempted to kill yourself? ☐ Yes ☐ No

If yes, how many times and how long ago? _____

In the past month:

Have you ever purposely hurt yourself? (cutting, burning, hitting, etc) ☐ Yes ☐ No

In the past (anytime):

Have you ever had thoughts or fantasies about harming other people? ☐ Yes ☐ No

Have you ever been violent towards other people? ☐ Yes ☐ No

Do you currently have access to a gun? ☐ Yes ☐ No

Medications:

List all prescribed (psychiatric and medical) and over the counter medications you take regularly. Include vitamins, supplements, etc. Use the back of the page for more space if needed.

Medication Name	Dose	Tablets Per Day	Date Started	Prescribed By

Please list all psychiatric medications that either have not been helpful or you stopped taking.

Medication Name	Dose	Length Taken	Last Taken	Reason Stopped

Are you allergic to any medication? ☐ Yes ☐ No

If so, please provide medication name and describe the reaction you had: _____

Have you ever had any serious reactions to any other specific medication? ☐ Yes ☐ No

If so, please provide medication name and describe the reaction you had: _____

Substance Use:

Caffeine: ☐ None ☐ Cups of coffee per day ___ ☐ Cans of soda per day ___ ☐ Energy drinks ___

Cigarettes: ☐Non-Smoker: Never smoked ☐Non-Smoker: Former smoker (When did you quit? ____)

☐ Smoker: Packs per day ____ Would you like to quit smoking? _____

Cannabis/Marijuana: ☐ None ☐ Currently using

If you currently use cannabis/marijuana, how many times a week do you use and through what methods?

_____

Is this use: ☐ Recreational ☐ Prescribed for a medical condition

Substance Abuse (please include prescription opiates and tranquilizers, such as Xanax, Ativan, Valium, etc)

Name of the drug	Age when first used	When last used	Frequency of use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any other additional comments? _____

If you are taking any medication from benzodiazepine family or tranquilizers, are you willing to have them tapered off over time in a safe manner? ☐ Yes ☐ No

Family History: Is there any immediate family history of any of the following psychiatric problems? Please write the relationship of the family member next to the problem (grandmother, mother, father, sister, son, etc).

☐ Depression _____ ☐ Mania _____

☐ Suicide or suicide attempts _____ ☐ Anxiety _____

☐ Schizophrenia _____ ☐ Paranoia _____

☐ Autism _____ ☐ Eating disorder _____

☐ Substance abuse _____ ☐ Obsessive compulsive disorder _____

☐ Hospitalization for mental/behavioral reason _____ ☐ Other _____

☐ Outpatient treatment for mental illness _____

Is your father: ☐ alive ☐ deceased ☐ unknown If deceased, what did he pass from? _____

what age was he? _____

Is your mother: ☐alive ☐ deceased ☐ unknown If deceased, what did she pass from? _____

what age was she? _____

Alcohol use: In the last year

(One standard drink = a regular size can of beer (12oz); a small glass of wine (5oz); one "shot" of liquor (1.5oz))
Please circle the answer that best describes your situation:

1. In the last year, how often do you have a drink containing alcohol?
   (0) Never (skip questions 2-10)
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 4 times a week
   (4) 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7,8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
6. How often during this last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
8. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (1) Yes, but not in the last year
   (2) Yes, during the last year
10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
    (0) No
    (1) Yes, but not in the last year
    (2) Yes, during the last year

If you drink alcohol:

1. Have you ever felt you needed to cut down on your drinking? ☐ Yes ☐ No
2. Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No
3. Have you ever felt guilty about drinking? ☐ Yes ☐ No
4. Have you ever felt you needed a drink first thing in the morning to steady your nerves? ☐ Yes ☐ No
5. Have you ever participated in a 12-step program (AA, NA, Gamblers, etc)? ☐ Yes ☐ No
6. Have you ever been treated in an outpatient drug-related program? ☐ Yes ☐ No
7. Have you ever been treated in an inpatient drug-alcohol rehab? ☐ Yes ☐ No
   If so, where? _____ If so, when? _____

Medical History:

Physician/Program Name Address Telephone Number

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date of last physical exam: _____ Weight: _____ Height: _____

Have you ever been hospitalized for a medical (physical) reason? ☐ Yes ☐ No

If yes, what was the date of hospitalization? _____

Have you ever had surgery? ☐ Yes ☐ No

Nature of Surgery Hospital Date

_____ _____ _____

_____ _____ _____

Please indicate if you have ever received any of the following testing: if not, please mark with "N/A"

	Received?	Date	Result and facility performed
CT Scan (Brain)	_____	_____	_____
MRI (Brain)	_____	_____	_____
EEG	_____	_____	_____
Neuropsychological Testing	_____	_____	_____

Do you have any of the following medical diagnosis?

	No	Yes. Please provide further information.
AIDS/HIV		
Blood pressure problems		
Cancer		
Diabetes		
Epilepsy/Seizures		
Gastrointestinal		
Head injury (head trauma)		
Heart disease		
Kidney disease		
Liver disease		
Neurological disease (stroke, neuropathy, headaches)		
Thyroid disease		
Musculoskeletal problems		
Sleep apnea		
Other relevant illnesses?		

Do you have any of these physical symptoms (currently)?

	No	Yes. Please provide further information.
Bleeding or bruising		
Cardiac (heart) problem (Heart-racing, chest pain, etc)		
Diarrhea or constipation		
Dizziness, lightheadedness, faint		
Feeling cold or hot		
Headaches		
Muscle spasms or weakness		
Weight change		
Other relevant symptoms?		

Emergency Contact:

Name:

Relation:

Phone Number(s):

Patient Signature: **Date:**

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HIPAA & CONSENT FORM

Patient's last name:	**First:**	**Middle Initial:**	**Marital status (circle one):** Single / Mar / Div / Sep / Wid
Former name (if applicable):	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Street address:		**Home phone no.:** ( )	**Cell phone no.:** ( )
P.O. box:	**City:**	**State:**	**ZIP Code:**

Race (check all that apply): ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race	**Ethnicity (check one):** ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Social Security No.: _____ - _____ - _____	**E-mail Address:**	**Preferred Pharmacy/Location:**

By signing below, I acknowledge the following:

- I give TCMH (TAK Center for Mental Health) consent to access my prescription history, including all past prescribed medication, in order to verify future prescription refills.
- I give TCMH consent to bill my insurance company for any fees related to services provided by their staff, perform reasonable and necessary medical examinations, testing and treatment at the discretion of its healthcare professionals based on their clinical judgment of my condition.
- I give TCMH consent to bill me directly for any charges denied by my insurance company, and for any charges incurred in the event of lack of insurance coverage at the time of care.
- I understand that TCMH is not responsible for any bills incurred by me for testing, imaging, or services provided by outside facilities, including those services ordered by their staff.
- I give TCMH consent to call, text, and/or email an appointment reminder to the phone number listed above. I understand that there may be a voicemail left for me at this phone number.
- I acknowledge that I have been given access to TCMH's Notice of Privacy Practices.
- I authorize TCMH to discuss my health information with the following person(s):

Name	Telephone #	Relation

❑ Self Only: *If checked, TCMH will not release your information to anyone except as outlined in our Notice of Privacy Practices. Please initial* _____

I release TAK Center for Mental Health (TCMH) from all responsibility and liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to TCMH, provided that I do so in writing and to the extent that we have already disclosed the information in reliance on this authorization.

_____ _____
Patient Signature (*or Guardian if patient is under the age of 18*) Date

_____ _____
Witness Signature Date

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
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?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					