Student Name:
Student Date of Birth:

Attentional Assessment– Student Packet

Dear Student,

Thank you for taking the time to complete the attached packet, as part of your evaluation for attentional concerns.

There are numerous developmental, environmental and medical factors that contribute to a person's ability to sustain attention. When attention problems occur for a long period of time, and interfere with a student's ability to function, they may be a sign of Attention-Deficit Hyperactivity Disorder (ADHD). However, there are times that impaired focus is not indicative of ADHD. At Boston University Student Health Services, we require a thorough assessment of all the factors that contribute to a person's ability to sustain attention in order to create a successful treatment plan. It is common that students experience difficulty with focus, organization and completing tasks on time during periods of stress, anxiety and depression and inattention alone is not indicative of an ADHD diagnosis.

Students who choose to seek treatment for attentional issues at Student Health Services, will first meet briefly with an Evaluation Clinician at Counseling & Psychiatric Services. The Evaluation Clinician will work to understand your reasons for seeking care and to determine the next best steps. All students will receive a packet of documents to complete and submit that will assist greatly at their Intake visit a few weeks later. The packet includes questionnaires for the student and her/his/their parent or guardian to complete. It also includes Release of Information forms that the student can use to gather neuropsychological testing reports, academic records and previous medical records and to grant the clinician permission to contact the member of your family who completes a questionnaire. An initial drug screen is required, and may again be required during the course of treatment. An updated medical evaluation may also be recommended. The clinician needs this information to help make an accurate diagnosis and appropriate recommendations. Recommendations may include behavioral or lifestyle changes, psychotherapy, study skills workshops and/or medication.

Students who prefer to seek evaluation and treatment outside of BU can seek a referral from the Counseling & Psychiatric Services referral coordinator.

Prior to the student's intake, the following information should be uploaded to Patient Connect (bu.edu/patientconnect) or emailed to shsecure@bu.edu.

- ☐ Completed Student Packet
- ☐ Completed Parent/ Guardian Packet
- ☐ Copies of any relevant school records and/or neuropsychological testing
- ☐ Completed release of information so that we can communicate with your parent/ guardian or your previous clinicians

If the documents are not received before your intake appointment, it will delay the evaluation of your attentional concerns. However, we recommend students attend the intake appointment regardless of whether you have completed the packets, as there are many elements of an evaluation that could be discussed in the initial appointment.

Student Name:
Student Date of Birth:

Student Questionnaire

Today's Date:

Instructions: Please check all that apply and if checked, please briefly elaborate.

Medical History

History of Heart-Related Symptoms:

- ☐ Abnormal Heart Rate or Rhythm
- ☐ High Blood Pressure
- ☐ Fainting or collapsing
- ☐ Chest pain with exercise
- ☐ Shortness of breath
- ☐ Have had an EKG. If so, results?
- ☐ Family History of Heart Attacks or Sudden Death before age 40
- ☐ No history of heart/cardiac problems or fainting

Additional Medical History:

- ☐ Head Injury or concussion
- ☐ Seizures/Epilepsy
- ☐ Sleep Disorder
- ☐ Tics/Tourette's
- ☐ Bed-wetting
- ☐ Lead poisoning
- ☐ Enlarged adenoids/tonsils
- ☐ Other?
- ☐ None

Psychiatric History

- ☐ Have received mental health services in the past (eg. evaluated or treated by a counselor, therapist, psychologist, psychiatrist)
- ☐ Have received psychiatric medication in the past
- ☐ Have engaged in self-harm or suicidal behavior in the past
- ☐ Have engaged in aggressive or violent behavior in the past
- ☐ Have been hospitalized in a psychiatric facility and/or received intensive day/residential treatment
- ☐ None

If yes to any of the above, please provide details below:

Family Psychiatric History

Please record which family member next to any checked item

- ☐ ADHD (likely)
- ☐ ADHD (confirmed)
- ☐ Alcohol or Drug Problems
- ☐ Anxiety
- ☐ Autism
- ☐ Bipolar/Manic Depression
- ☐ Depression
- ☐ Psychosis or Schizophrenia
- ☐ Tourette's Disorder/Tic Disorder
- ☐ Suicide
- ☐ Other
- ☐ None

Student Name:
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Functioning at School: ***Please elaborate on functioning in both Kindergarten-8th Grade and in High School. Please use additional space as needed.***

	Kindergarten-8th Grade	**High School**
Average Grades		
Report Card Comments		
Behavior Problems?		
Social Problems?		
Homework Attitude		
Organization Skills		
Accommodations		
Tutoring		
Achieved Potential?		

Mental Health Symptom Inventory

Instructions to Informant: Check the box that best describes your typical behavior each day.	Not at all (0)	Some of the time (1)	Much of the time (2)	Very often (3)	N/A
Fail to give close attention to details, make careless mistakes					
Have difficulty sustaining attention in tasks or fun activities					
Do not seem to listen when spoken to directly					
Do not follow through on instructions and fail to finish work					
Have difficulty organizing tasks and activities					
Avoid tasks that require sustained mental effort					
Lose things					
Am easily distracted					
Am forgetful in daily activities					
Am fidgety or squirm in my seat					
Leave my seat when sitting is expected					
Feel restless					
Have difficulty doing fun things quietly					
Am always ‘on the go’					
Talk excessively					
Blurt out answers before questions have been completed					
Have difficulty waiting my turn					
Interrupt or intrude on others					

	Not at all (0)	Some of the time (1)	Much of the time (2)	Very often (3)	N/A
Make repetitive movements that I can't control (blinking, twitching, etc.)					
Make repetitive noises that I can't control (sniffing, throat clearing, etc.)					
Worry about health, loved ones, catastrophes, etc.					
Am unable to relax					
Have chronic unexplained aches, pains or physical symptoms (headaches, tension, stomach aches, etc.)					
Have intrusive, repetitive thoughts that make no sense					
Engage in repetitive rituals (hand washing, checking, etc.)					
Have sudden spikes of intense anxiety					
Am very shy					
Pull out my hair, eyebrows					
Pick my skin or bite my nails					
Refuse to speak up in public or in performance situations					
Have unreasonable fears that interfere with regular activities					
Feel sad or unhappy					
Don't enjoy things in my life					
Feel worthless					
Have low energy					
Feel hopeless and pessimistic about the future					
Have excessive feelings of guilt or self-blame					
Have noticed changes in my appetite					
Have noticed changes in my sleep					
Feel agitated, sluggish or slowed down					

	Not at all (0)	Some of the time (1)	Much of the time (2)	Very often (3)	N/A
IN THE PAST, I have hurt myself (cutting, burning, etc.)					
IN THE PAST, I have had suicidal thoughts					
IN THE PAST, I have attempted suicide					
Have distinct periods of elevated mood					
Have sudden increases in self esteem					
Have racing thoughts					
Don't need to sleep much and I'm not tired					
Engage in high risk activities (spending too much money, having impulsive sex, etc.)					
Have distinct periods of increased activity and productivity					
Have lots of changes in my mood					
Hear voices or see things that others can't					
Worry that other people mean to do me harm					
Can receive special messages from TVs, magazines, books or advertisements					
Have special perceptual abilities that others do not have					
Have difficulty falling asleep					
Have difficulty staying asleep					
Nap during the day					
Fall asleep unexpectedly during the day					
Go to bed late and sleep in late					
Sleep walk					
Have nightmares					
Snore a lot					
Have a restless feeling in my legs while trying to sleep					

	Not at all (0)	Some of the time (1)	Much of the time (2)	Very often (3)	N/A
Have different sleep patterns day to day					
Worry a lot about how my body looks					
Have a lot of rules about what I eat					
Count calories					
Limit the calories I eat					
Eat large quantities of food in one sitting					
Vomit after meals					
Use weight lowering medications or pills					
Exercise regularly					
	Not at all (0)	Some of the time (1)	Much of the time (2)	Very often (3)	N/A
Use caffeine					
Use nicotine					
Use marijuana					
Use alcohol					
Use prescription drugs that aren't mine					
Use any other street drugs					
	Not at all (0)	Some of the time (1)	Much of the time (2)	Very often (3)	N/A
Have trouble making or keeping friends or relationships					
Feel empty, especially when I'm alone					
Feel like people leave me or reject me a lot					
Try to hurt myself to manage my feelings					
Am not really sure who I am or what my goals are in life					
Get angry at other people					
Feel like I'm not real or the world isn't real					
Space out or 'lose time'					

	Not at all (0)	Some of the time (1)	Much of the time (2)	Very often (3)	N/A
Actively defy or refuse to comply with rules					
Am easily annoyed by others					
Have been accused of bullying others					
Have started physical fights					
Have engaged in criminal activity					

Student Name:
Student Date of Birth:

Wender Utah Rating Scale

	As a child I was (or had):	not at all or very slightly	mildly	moder-ately	quite a bit	very much
1	active restless always on the go	0	1	2	3	4
2	afraid of things	0	1	2	3	4
3	concentration problems easily distracted	0	1	2	3	4
4	anxious worrying	0	1	2	3	4
5	nervous fidgety	0	1	2	3	4
6	inattentive daydreaming	0	1	2	3	4
7	hot- or short-tempered low boiling point	0	1	2	3	4
8	shy sensitive	0	1	2	3	4
9	temper outbursts tantrums	0	1	2	3	4
10	trouble with stick-to-it-tiveness not following through. failing to finish things started	0	1	2	3	4
11	stubborn strong-willed	0	1	2	3	4
12	sad or blue depressed unhappy	0	1	2	3	4
13	incautious. dare-devilish involved in pranks	0	1	2	3	4
14	not getting a kick out of things dissatisfied with life	0	1	2	3	4
15	disobedient with parents rebellious sassy	0	1	2	3	4
16	low opinion of myself	0	1	2	3	4
17	irritable	0	1	2	3	4
18	outgoing friendly enjoyed company of people	0	1	2	3	4
19	sloppy disorganized	0	1	2	3	4
20	moody ups and downs	0	1	2	3	4
21	angry	0	1	2	3	4
22	friends popular	0	1	2	3	4
23	well-organized tidy neat	0	1	2	3	4
24	acting without thinking impulsive	0	1	2	3	4
25	tendency to be immature	0	1	2	3	4
26	guilty feelings regretful	0	1	2	3	4
27	losing control of myself	0	1	2	3	4
28	tendency to be or act irrational	0	1	2	3	4
29	unpopular with other children didn't keep friends for long didn't get along with other children	0	1	2	3	4

Student Name:
Student Date of Birth:

	As a child I was (or had):	not at all or very slightly	mildly	moder-ately	quite a bit	very much
30	poorly coordinated did not participate in sports	0	1	2	3	4
31	afraid of losing control of self	0	1	2	3	4
32	well-coordinated picked first in games	0	1	2	3	4
33	liked playing outside	0	1	2	3	4
34	running away from home	0	1	2	3	4
35	getting into fights	0	1	2	3	4
36	teasing other children	0	1	2	3	4
37	leader bossy	0	1	2	3	4
38	difficulty getting awake	0	1	2	3	4
39	follower led around too much	0	1	2	3	4
40	trouble seeing things from someone else's point of view	0	1	2	3	4
41	trouble with authorities trouble with school visits to principal's office	0	1	2	3	4
42	trouble with police booked convicted	0	1	2	3	4

	Medical problems as a child	not at all or very slightly	mildly	moder-ately	quite a bit	very much
43	headaches	0	1	2	3	4
44	stomachaches	0	1	2	3	4
45	constipation	0	1	2	3	4
46	diarrhea	0	1	2	3	4
47	food allergies	0	1	2	3	4
48	other allergies	0	1	2	3	4
49	bedwetting	0	1	2	3	4
	As a child in school I was (or had)	not at all or very slightly	mildly	moder-ately	quite a bit	very much
50	overall a good student fast	0	1	2	3	4
51	overall a poor student slow learner	0	1	2	3	4
52	slow in learning to read	0	1	2	3	4
53	slow reader	0	1	2	3	4
54	trouble reversing letters	0	1	2	3	4
55	problems with spelling	0	1	2	3	4
56	trouble with mathematics or numbers	0	1	2	3	4

Student Name:
Student Date of Birth:

	As a child in school I was (or had)	not at all or very slightly	mildly	moder-ately	quite a bit	very much
57	bad handwriting	0	1	2	3	4
58	able to read pretty well but never really enjoyed reading	0	1	2	3	4
59	not achieving up to potential	0	1	2	3	4
60	repeating grades	0	1	2	3	4
61	suspended or expelled	0	1	2	3	4

Student Name:
Student Date of

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – SELF REPORT (WFIRS-S)

Patient Name:_____ **Date:**_____**Date of Birth:** _____

Work:_____**Full Time**_____**Part Time**_____**Other:** _____

School:_____ **Full Time**_____**Part Time** _____

Circle the number for the rating that best describes how your emotional or behavioural problems have affected each item in the last month.

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
A	**FAMILY**					
1	Having problems with family					
2	Having problems with spouse/partner					
3	Relying on others to do things for you					
4	Causing fighting in the family					
5	Makes it hard for the family to have fun together					
6	Problems taking care of your family					
7	Problems balancing your needs against those of your family					
8	Problems losing control with family					
B	**WORK**					
1	Problems performing required duties					
2	Problems with getting your work done efficiently					
3	Problems with your supervisor					
4	Problems keeping a job					
5	Getting fired from work					
6	Problems working in a team					
7	Problems with your attendance					
8	Problems with being late					
9	Problems taking on new tasks					
10	Problems working to your potential					
11	Poor performance evaluations					
C	**SCHOOL**					
1	Problems taking notes					
2	Problems completing assignments					
3	Problems getting your work done efficiently					
4	Problems with teachers					
5	Problems with school administrators					
6	Problems meeting minimum requirements to stay in school					
7	Problems with attendance					
8	Problems with being late					
9	Problems with working to your potential					
10	Problems with inconsistent grades					
D	**LIFE SKILLS**					
1	Excessive or inappropriate use of internet, video games or TV					
2	Problems keeping an acceptable appearance					
3	Problems getting ready to leave the house					
4	Problems getting to bed					
5	Problems with nutrition					

Student Name:
Student Date of

6	Problems with sex					

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
7	Problems with sleeping					
8	Getting hurt or injured					
9	Avoiding exercise					
10	Problems keeping regular appointments with doctor/dentist					
11	Problems keeping up with household chores					
12	Problems managing money					
E	**SELF-CONCEPT**					
1	Feeling bad about yourself					
2	Feeling frustrated with yourself					
3	Feeling discouraged					
4	Not feeling happy with your life					
5	Feeling incompetent					
F	**SOCIAL**					
1	Getting into arguments					
2	Trouble cooperating					
3	Trouble getting along with people					
4	Problems having fun with other people					
5	Problems participating in hobbies					
6	Problems making friends					
7	Problems keeping friends					
8	Saying inappropriate things					
9	Complaints from neighbours					
G	**RISK**					
1	Aggressive driving					
2	Doing other things while driving					
3	Road rage					
4	Breaking or damaging things					
5	Doing things that are illegal					
6	Being involved with the police					
7	Smoking cigarettes					
8	Smoking marijuana					
9	Drinking alcohol					
10	Taking "street" drugs					
11	Sex without protection (birth control, condom)					
12	Sexually inappropriate behaviour					
13	Being physically aggressive					
14	Being verbally aggressive					

Number of Items Scored '**2**' or '**3**'

A	**Family**			/
B	**Work**			/
C	**School**			/
D	**Life Skills**			/
E	**Self-concept**			/
F	**Social**			/
G	**Risky**			/
	Total			

Total Score

A	**Family**		/
B	**Work**		/
C	**School**		/
D	**Life Skills**		/
E	**Self-concept**		/
F	**Social**		/
G	**Risky**		/
	Total		

Mean Score
(N/A items not included in calculation)

A	**Family**	
B	**Work**	
C	**School**	
D	**Life Skills**	
E	**Self-concept**	
F	**Social**	
G	**Risky**	
	Total	

Student Name:
Student Date of

*Calculated from_____answered questions.