NAAAT Version 3.0

NEUROHAVEN ADULT ADHD ASSESSMENT TOOL [Version 3.0]

Client Information:

- **Name:** [_____]
- **Date of Birth:** [_____]
- **Age:** [_____]
- **Gender:** [_____]
- **Date of Ax:** [_____]
- **Assessor:** [_____]
- **Referral Source:** [_____]
- **Driving Licence:** Y / N _____ Points: Y / N
- **Video Ax**: Y / N

1. Reason for Referral

Brief description of the client's concerns and reasons for seeking an ADHD assessment.

Current Social & Employment Circumstances:

- Finances:
- Accommodation:
- Significant Relationships:

2. Background Information

Developmental History

Symptom	Yes	No
Delayed speech development	[ ]	[ ]
Difficulty following instructions	[ ]	[ ]
Frequent tantrums or emotional outbursts	[ ]	[ ]
Impulsivity from a young age	[ ]	[ ]
Poor coordination or clumsiness	[ ]	[ ]
Restless or fidgety as a child	[ ]	[ ]
Struggled with transitions between activities	[ ]	[ ]
Trouble maintaining eye contact	[ ]	[ ]
Frequently lost items or was forgetful	[ ]	[ ]
Difficulty making or keeping friends	[ ]	[ ]
Strong emotional reactions to small problems	[ ]	[ ]

Educational & Occupational History

Symptom	Yes	No
Difficulty focusing in class or on work tasks	[ ]	[ ]
Easily distracted by noises or other people	[ ]	[ ]
Trouble organizing tasks and materials	[ ]	[ ]
Procrastination or difficulty starting assignments	[ ]	[ ]
Misses deadlines frequently	[ ]	[ ]
Struggled with reading comprehension	[ ]	[ ]
Problems with note-taking or following lectures	[ ]	[ ]
Trouble finishing projects without supervision	[ ]	[ ]
Difficulty retaining information from meetings or lessons	[ ]	[ ]
Frequently switching jobs due to boredom or difficulty	[ ]	[ ]

Social & Family History

Symptom	Yes	No
Difficulty maintaining friendships	[ ]	[ ]
Frequently interrupts conversations	[ ]	[ ]
Struggles with turn-taking in conversations	[ ]	[ ]
Often forgets social commitments or plans	[ ]	[ ]
Impulsive decision-making in relationships	[ ]	[ ]
History of conflicts with authority figures	[ ]	[ ]
Family history of ADHD or related conditions	[ ]	[ ]
History of mood swings or emotional dysregulation	[ ]	[ ]
Difficulty managing personal finances due to impulsive spending	[ ]	[ ]
Experiences sensory sensitivities (e.g., noise, touch)	[ ]	[ ]

3. Clinical Assessment

- **Mental State Examination (MSE)**

Domain	Observation
Appearance	[ ] Well-groomed [ ] Dishevelled [ ] Unkempt
Behaviour	[ ] Cooperative [ ] Restless [ ] Agitated
Speech	[ ] Normal rate & tone [ ] Pressured [ ] Slurred [ ] Slow
Mood	[ ] Euthymic [ ] Depressed [ ] Anxious [ ] Irritable
Affect	[ ] Appropriate [ ] Blunted [ ] Labile [ ] Restricted
Thought Process	[ ] Logical [ ] Tangential [ ] Circumstantial [ ] Disorganized
Thought Content	[ ] Normal [ ] Preoccupied [ ] Delusional [ ] Suicidal thoughts
Perception	[ ] No hallucinations [ ] Auditory [ ] Visual
Cognition	[ ] Alert [ ] Distractible [ ] Impaired memory [ ] Difficulty concentrating
Insight	[ ] Good [ ] Partial [ ] Poor
Judgment	[ ] Good [ ] Impulsive [ ] Impaired
Motor Activity	[ ] Normal [ ] Increased [ ] Decreased

- **Past Psychiatric History**

ASC: *communication social difficulties*
Dyslexia: *Reading Spelling habits Processing speed L/R*
Dyspraxia: *L/R disorientation Difficulty driving / maps Clumsy*
Handwriting: *(dysgraphia)*
Tics: *yes or no onset age, motor/vocal, duration*
Dyscalculia*: Maths, Eg 36 + 37, Analogue Clock*

- **History of Trauma:** [ ] Yes [ ] No
- **Safeguarding Risk: Y / N**

- **Past Medical History:** ***[****OCD / ED / PD / Depression / Addiction / Anxiety / Epilepsy]*

- **Alcohol & Drugs:**

- **Medication:**

Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**
Name	**Dose**	**Frequency**

- **Family Medical/Psychiatric History:**

Glaucoma:
Raynaud's:
Lactose intolerant:
Pregnant:

Nicotine:

Caffeine:

Family History

Mother:

Father:

Siblings:

Other:

CHECK	MEASUREMENT/OBSERVATION
Blood Pressure	_____ / _____ mmHg
Heart Rate	_____ bpm
Weight	_____ kg
Height	_____ cm
BMI	_____
ECG Required	[ ] Yes [ ] No
Cardiac History	[ ] Yes [ ] No (Details: _____)
Hypertension	[ ] Yes [ ] No
History of Seizures	[ ] Yes [ ] No
Family History of Sudden Death	[ ] Yes [ ] No
History of Substance Use	[ ] Yes [ ] No (Details: _____)
Sleep Issues	[ ] Yes [ ] No
Neurological Disorders	[ ] Yes [ ] No (Details: _____)
Allergies	[ ] Yes [ ] No (Details: _____)

4. Symptom Assessment (DSM-5 Criteria)

Inattention Symptoms

Symptom	Childhood	Adulthood
Careless mistakes/lack of attention to details	[ ]	[ ]
Difficulty sustaining attention	[ ]	[ ]
Doesn't listen when spoken to directly	[ ]	[ ]
Doesn't follow through on instructions/tasks	[ ]	[ ]
Disorganized with tasks/activities	[ ]	[ ]
Avoids tasks requiring mental effort	[ ]	[ ]
Often loses/misplaces items	[ ]	[ ]
Easily distracted by external stimuli	[ ]	[ ]
Forgetful in daily activities	[ ]	[ ]

Hyperactivity-Impulsivity Symptoms

Symptom	Childhood	Adulthood
Fidgety or restless	[ ]	[ ]
Leaves seat in inappropriate situations	[ ]	[ ]
Feels restless or runs about excessively	[ ]	[ ]
Difficulty engaging in quiet activities	[ ]	[ ]
Acts "on the go" or hyperactive	[ ]	[ ]
Talks excessively	[ ]	[ ]
Blurts out answers prematurely	[ ]	[ ]
Difficulty waiting their turn	[ ]	[ ]
Interrupts or intrudes on others	[ ]	[ ]

Domains of impairment:
- Education
- Employment
- Mental Health
- Self Care
- Social / relationships
- Addiction / Substance use

Criteria
< 12 Years old
≥ 18 Years old
≥ 2 Domains

5. Assessment Tools Used

Tool	Completed	Score
ASRS (Adult ADHD Self-Report Scale)	[ ] Yes [ ] No	____
Conners' Adult ADHD Rating Scales	[ ] Yes [ ] No	____
Wender Utah Rating Scale (WURS)	[ ] Yes [ ] No	____
WAIS-IV (if cognitive assessment required)	[ ] Yes [ ] No	____
Other: _____	[ ] Yes [ ] No	____

Self-Report:
[ ] Yes [ ] No

Informant Report
[ ] Yes [ ] No

6. Differential Diagnosis Considerations

Condition	Considered	Ruled Out
Anxiety Disorders	[ ] Yes	[ ] Yes
Depression	[ ] Yes	[ ] Yes
Learning Disabilities	[ ] Yes	[ ] Yes
Autism Spectrum Disorder	[ ] Yes	[ ] Yes
Bipolar Disorder	[ ] Yes	[ ] Yes
Personality Disorders	[ ] Yes	[ ] Yes
Substance Use Disorder	[ ] Yes	[ ] Yes
Other: _____	[ ] Yes	[ ] Yes

7. Summary & Clinical Impression

- **Overall Findings:** Summarized key symptoms and functional impact.

- **Diagnosis:** ADHD Type (Inattentive / Hyperactive-Impulsive / Combined).

- **Severity Level:** Mild / Moderate / Severe.

- **Functional Impairment:** Education / Employment / Social / Relationships / Self-Care / Mental Health.

- **Additional Observations:** Any comorbid conditions or unique patient factors.

8. Recommendations & Treatment Plan

- **Psychoeducation & Lifestyle Modifications**

Recommendation	Advised
Psychoeducation on ADHD	[ ] Yes [ ] No
Sleep hygiene strategies	[ ] Yes [ ] No
Exercise recommendations	[ ] Yes [ ] No
Dietary modifications	[ ] Yes [ ] No
Stress management techniques	[ ] Yes [ ] No

- **Pharmacological Treatment**

Medication Type	Considered	Initiated
Stimulants (e.g., Methylphenidate)	[ ] Yes	[ ] Yes
Non-stimulants (e.g., Atomoxetine)	[ ] Yes	[ ] Yes
Off-label treatments	[ ] Yes	[ ] Yes
No medication recommended	[ ] Yes	[ ] Yes

- **Psychological & Behavioural Interventions**

Intervention	Recommended
Cognitive Behavioural Therapy (CBT)	[ ] Yes
ADHD Coaching	[ ] Yes
Occupational Therapy	[ ] Yes
Group Therapy	[ ] Yes
Other: _____	[ ] Yes

- **Workplace & Academic Accommodations**

Support	Recommended
Extended deadlines	[ ] Yes
Flexible working hours	[ ] Yes
Noise reduction strategies	[ ] Yes
Assistive technology	[ ] Yes
Support Letter	[ ] Yes

Follow-Up Plan:

- **Next Review Date:** [Date]

- **Monitoring Plan:** Symptom progression, medication tolerance, therapy outcomes.

- **Further Referrals:** Psychiatry / Psychology / Occupational Therapy / Other.

Clinician's Name & Credentials:
[Name]

[Signature]

[Date]