

BAARS-IV: Self-Report: Current Symptoms

Name: _____ Date: _____

Sex: (circle one) Male Female Age: _____

For the first 27 items, please circle the number next to each item below that best describes your behavior **DURING THE PAST 6 MONTHS**. Then answer the remaining three questions. Please ignore the sections marked "Office Use Only."

Section 1 (Inattention)	Never or rarely	Some- times	Often	Very often
1. Fail to give close attention to details or make careless mistakes in my work or other activities	1	2	3	4
2. Difficulty sustaining my attention in tasks or fun activities	1	2	3	4
3. Don't listen when spoken to directly	1	2	3	4
4. Don't follow through on instructions and fail to finish work or chores.	1	2	3	4
5. Have difficulty organizing tasks and activities	1	2	3	4
6. Avoid, dislike, or am reluctant to engage in tasks that require sustained mental effort	1	2	3	4
7. Lose things necessary for tasks or activities	1	2	3	4
8. Easily distracted by extraneous stimuli or irrelevant thoughts.	1	2	3	4
9. Forgetful in daily activities	1	2	3	4
Office Use Only (Section 1) Total Score: _____ Symptom Count: _____				
Section 2 (Hyperactivity)	Never or rarely	Some- times	Often	Very often
10. Fidget with hands or feet or squirm in seat	1	2	3	4
11. Leave my seat in classrooms or in other situations in which remaining seated is expected	1	2	3	4
12. Shift around excessively or feel restless or hemmed in	1	2	3	4
13. Have difficulty engaging in leisure activities quietly (feel uncomfortable, or am loud or noisy)	1	2	3	4
14. I am "on the go" or act as if "driven by a motor" (or I feel like I have to be busy or always doing something)	1	2	3	4
Office Use Only (Section 2) Total Score: _____ Symptom Count: _____				

(continued)

Section 3 (Impulsivity)	Never or rarely	Some-times	Often	Very often
15. Talk excessively (in social situations)	1	2	3	4
16. Blur out answers before questions have been completed, complete others' sentences, or jump the gun	1	2	3	4
17. Have difficulty awaiting my turn	1	2	3	4
18. Interrupt or intrude on others (butt into conversations or activities without permission or take over what others are doing)	1	2	3	4
Office use only (Section 3) Total Score: _____ Symptom Count: _____				
Section 4 (Sluggish Cognitive Tempo)	Never or rarely	Some-times	Often	Very often
19. Prone to daydreaming when I should have been concentrating on something or working	1	2	3	4
20. Have trouble staying alert or awake in boring situations	1	2	3	4
21. Easily confused	1	2	3	4
22. Easily bored	1	2	3	4
23. Spacey or "in a fog"	1	2	3	4
24. Lethargic, more tired than others	1	2	3	4
25. Underactive or have less energy than others	1	2	3	4
26. Slow moving	1	2	3	4
27. I don't seem to process information as quickly or as accurately as others.	1	2	3	4
Office use only (Section 4) Total Score: _____ Symptom Count: _____				
Total Scores for Entire Scale:				
Sum of Sections Raw Scores 1 – 3 Total ADHD Score _____				
Section 1 Symptom Count _____				
Sum of Sections 2 and 3 Symptom Counts _____				
Total ADHD Symptom Count _____ (Sum of 1 – 3)				
SCT Symptom Count _____				

(continued)

Section 5

28. Did you experience *any* of these 27 symptoms at least “Often” or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)

29. If so, how old were you when these symptoms began? (Fill in the blank)

I was _____ years old.

30. If so, in which of these settings did those symptoms impair your functioning? Place a *check mark* (✓) next to all of the areas that apply to you.

_____ School
 _____ Home
 _____ Work
 _____ Social Relationships

If you checked any of the domains in item # 30 indicating settings in which symptoms impair your functioning, please provide examples of your current difficulties in the appropriate spaces below.

School: _____

Home: _____

Work: _____

Social Relationships: _____

FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.

BAARS-IV: Self-Report: Childhood Symptoms

Name: _____ Date: _____

Sex: (circle one) Male Female Age: _____

For the first 18 items, please circle the number next to each item below that best describes your behavior when you were a child **BETWEEN 5 AND 12 YEARS OF AGE**. Then answer the remaining two questions. Please ignore the sections marked "Office Use Only."

Section 1 (Inattention)	Never or rarely	Some- times	Often	Very often
1. Failed to give close attention to details or made careless mistakes in my work or other activities	1	2	3	4
2. Had difficulty sustaining my attention in tasks or fun activities	1	2	3	4
3. Didn't listen when spoken to directly	1	2	3	4
4. Didn't follow through on instructions and failed to finish work or chores.	1	2	3	4
5. Had difficulty organizing tasks and activities	1	2	3	4
6. Avoided, disliked, or was reluctant to engage in tasks that required sustained mental effort	1	2	3	4
7. Lost things necessary for tasks or activities	1	2	3	4
8. Was easily distracted by extraneous stimuli or irrelevant thoughts.	1	2	3	4
9. Was forgetful in daily activities	1	2	3	4
Office Use Only (Section 1) Total Score: _____ Symptom Count: _____				
Section 2 (Hyperactivity-Impulsivity)	Never or rarely	Some- times	Often	Very often
10. Fidgeted with hands or feet or squirmed in seat	1	2	3	4
11. Left my seat in classrooms or in other situations in which remaining seated was expected	1	2	3	4
12. Shifted around excessively or felt restless or hemmed in	1	2	3	4
13. Had difficulty engaging in leisure activities quietly (felt uncomfortable, or was loud or noisy)	1	2	3	4
14. Was "on the go" or acted as if "driven by a motor"	1	2	3	4
15. Talked excessively	1	2	3	4

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16. Blurted out answers before questions had been completed, completed others' sentences, or jumped the gun	1	2	3	4
17. Had difficulty awaiting my turn	1	2	3	4
18. Interrupted or intruded on others (butted into conversations or activities without permission or took over what others were doing)	1	2	3	4
Office Use Only (Section 2) Total Score _____ Symptom Count _____				
Sum of Sections 1 – 2 for Total Scores _____ Sum of Sections 1 – 2 for Symptom Counts _____				
Section 3				
19. Did you experience <i>any</i> of these 18 symptoms at least “Often” or more frequently (Did you circle a 3 or a 4 above)? No Yes (Circle one)				
20. If so, in which of these settings did those symptoms impair your functioning? Place a <i>check mark</i> (✓) next to all of the areas that apply to you.				
_____ School				
_____ Home				
_____ Social Relationships				
If you checked any of the domains in item # 20 indicating settings in which symptoms impaired your functioning, please provide examples of those childhood difficulties in the appropriate spaces below.				
School: _____				

Home: _____				

Social Relationships: _____				

FEEL FREE TO ATTACH ADDITIONAL PAGES TO FULLY ANSWER THESE QUESTIONS IF NECESSARY.