Mind Rejuvenation, LLC
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ADHD Differential Diagnosis Screening (DDS)

Patient: _____ **DOB:** _____ **Date:** _____

The following questions help your provider determine whether symptoms may be related to ADHD or another condition.

Sleep

☐ Yes ☐ No Do you regularly sleep fewer than 6 hours per night?
☐ Yes ☐ No Do you feel excessively tired during the day?
☐ Yes ☐ No Do you snore loudly or wake up gasping for air during sleep?
☐ Yes ☐ No Have you ever been evaluated for a sleep disorder?

Anxiety

☐ Yes ☐ No Do you frequently feel excessive worry or nervousness?
☐ Yes ☐ No Do racing thoughts occur primarily during periods of anxiety or stress?
☐ Yes ☐ No Do you avoid situations because of worry or fear?

Depression

☐ Yes ☐ No Have you experienced periods of low mood lasting two weeks or longer?
☐ Yes ☐ No During these times did you lose interest in activities you usually enjoy?
☐ Yes ☐ No Do concentration difficulties occur mainly when your mood is low?

Bipolar Spectrum Screening

☐ Yes ☐ No Have you experienced periods lasting several days where you had unusually high energy or needed very little sleep?
☐ Yes ☐ No During these times did you feel unusually confident, talkative, or impulsive?
☐ Yes ☐ No Have others commented that your mood or energy shifts dramatically at times?

Trauma History

☐ Yes ☐ No Have you experienced a traumatic event that still affects your thoughts, sleep, or emotions?
☐ Yes ☐ No Do intrusive memories or hypervigilance interfere with your concentration?

Signature: Person completing form

Name: _____ Signature: _____