NHS
Derby and Derbyshire
Integrated Care Board

Adult ASD/ADHD Pre-Assessment Patient Questionnaire

ASD – Autism Spectrum Disorder
ADHD – Attention Deficit Hyperactive Disorder

This form is key part of your referral for ASD/ADHD assessment and/or Treatment, please take your time to complete this in full. You may find benefit in completing in small parts, and asking for help from those close to you, or who knew you when you were under 12.

Once complete please return to your registered General Practice or Health Professional completing your ASD/ADHD referral.

Your Personal Details and Contact Information

Title	
Full Name	
Gender Assigned at Birth	
Date of Birth	
Address	
Contact Number	
Email Address	
Do you have any relatives that the ASD/ADHD assessor could contact to get information about what you were like as a child and now.	Yes ☐ No ☐ If answered yes, please could you provide their contact details below.

Current Symptoms

Please describe your symptoms and at what age they presented.

What impact have the symptoms had on your life such as education, employment, home life and relationships?
Have other people commented on your behaviours? Such as parents, partners, teachers, or employers? If so, please provide details.
What are you hoping to get out of the assessment?

Education and Employment

What type of school did you attend?

School Type	Please Tick
Mainstream State School	
Mainstream Private School	
School for children with emotional and behavioural difficulties	
School for children with Autism	
School for children with learning disabilities	

School for children with physical disabilities and/or sensory impairments	
Other – Please specify	

Have you ever received a statement of Special Educational Needs (SEN) or had an Educational Health Care Support Plan (EHCP) during your education?
Yes ☐ No ☐
Please state your highest level of qualification to date:

Are you currently in paid employment?
Yes ☐ No ☐

Please give a brief list of previous employment and reason for leaving.

Dates (Year)	Company	Job Title	Type of work	Reason for leaving

Family Structure

Please complete the following information about your birth mother, has your mother ever been diagnosed with a mental health condition or other diagnosis?
Yes ☐ No ☐ If answered yes, please could you provide details.
Has your mother ever been diagnosed with a physical health condition?
Yes ☐ No ☐ If answered yes, please could you provide details.

Please complete the following information about your birth father, has your father ever been diagnosed with a mental health condition or other diagnosis?
Yes ☐ No ☐ If answered yes, please could you provide details.

Has your father ever been diagnosed with a physical health condition?
Yes ☐ No ☐ If answered yes, please could you provide details.

Are there any other members of your family who have a diagnosis of ASD/ADHD or other neurodivergent conditions (such as Autism, Dyslexia or Dyspraxia).
Please could you give any information about your family that you feel may be appropriate (Such as grandparents, children etc)

Forensic History

Have you ever been investigated by the police or charged with a criminal offence?
Yes ☐ No ☐ If answered yes, please could you provide details.
Are you currently open to Probation Services?
Yes ☐ No ☐ If answered yes, please could you provide details.

Medical History

Current Medication
Do you have any diagnosed physical health conditions?
Yes ☐ No ☐ If answered yes, please could you provide details.
Is there a chance you could be pregnant?
Yes ☐ No ☐
Are you currently breast feeding?

Yes ☐ No ☐

Do you drink alcohol? How often? How much?
Do you drink energy drinks or consume caffeine? How often? How much?
Do you take other substances, if yes, What? How much? How often?
Do you take unprescribed medication? How much? How often?
Do you take prescribed medication? If yes, do you take this as advised by your GP / Health professional?
If yes to any of the above questions, why do you use the substance? How does it make you feel?

Have you ever been diagnosed with the following?	**Please Tick**
Autism Spectrum Disorder (Including Asperger's)	
Bipolar Disorder	
Depression	
Dyslexia	
Dyspraxia	
Dyscalculia	
Emotional Unstable Personality Disorder	
Functional Neurological Disorder	
General Anxiety Disorder	
Genetic Disorder	

Hearing problems	
Language Delay or Language Disorders	
Learning disability or global developmental delay	
Obsessive Compulsive Disorder (OCD)	
Personality Disorder	
Tourette's Syndrome	
Schizophrenia	
Sleep Difficulties	
Substance Misuse	
Visual Problems	
Other	

Have you ever felt suicidal?
Yes ☐ No ☐
If yes, have you ever planned or attempted suicide?
Yes ☐ No ☐ If answered yes, please give some details.

Have you ever been referred to any of the following professionals?	**Please Tick**
Clinical Psychologist	
Disability Employment Advisor	
Educational Psychologist	
Forensic Psychologist	
Nurse	
Occupational Therapist	
Probation Officer	
Psychiatrist	
Social Work	
Speech and Language Therapy	
Support Worker	
Other, please specify.	

Are you currently receiving any of the following benefits?	**Please Tick for yes**
Disability Living Allowance/ Personal Independence Payment	
Employment Support Allowance	
Housing Benefit	
Other, please give details	