ADHD ASSESSMENT

Clinician Manual & Evaluation Guide

MindLift Alliance Counseling, Assessment & Education Services

A step-by-step, multi-method framework for evaluating attention, hyperactivity, impulsivity, executive functioning, impairment, and differential diagnosis.

Clinical Use Notice

This guide is a clinician reference. Use only within your professional scope, training, state law, payer requirements, and organizational policy. Rating scales support clinical judgment; they do not independently establish an ADHD diagnosis.

Practical tools for lasting change.

1. Core Principle: ADHD Is a Clinical Diagnosis

A sound ADHD evaluation combines symptom history, developmental course, functional impairment, observations, collateral information, rating scales, and careful differential diagnosis. No single questionnaire, computer task, school report, or interview should be treated as definitive on its own.

The Diagnostic Question

- Are clinically significant symptoms of inattention and/or hyperactivity-impulsivity present?
- Did several symptoms begin during the developmental period required by current diagnostic criteria?
- Are symptoms present across more than one meaningful setting when the diagnosis requires this?
- Do symptoms cause clear impairment in academic, occupational, social, family, or daily functioning?
- Are the symptoms better explained by another mental health, developmental, medical, sleep, substance-related, or environmental condition?
- What co-occurring conditions are present and how do they change the treatment plan?

MindLift Clinical Lens

Assess the whole person, not just the checklist. ADHD symptoms can be real while anxiety, trauma, sleep problems, learning difficulties, mood symptoms, family stress, or other conditions are also contributing.

2. Step-by-Step ADHD Assessment Workflow

1. Clarify the referral question and who is requesting the evaluation.
2. Obtain informed consent/assent and explain the limits of the assessment.
3. Conduct a clinical and developmental interview.
4. Gather symptoms across settings and over time.
5. Obtain collateral information from appropriate sources.
6. Use validated ADHD rating scales and broad behavioral/emotional screening measures as indicated.
7. Assess functional impairment - not symptoms alone.
8. Screen for differential diagnoses and comorbidities.
9. Review medical, sleep, medication, substance, learning, and psychosocial factors.
10. Integrate all data into a clinical formulation.
11. Provide feedback, diagnosis when supported and within scope, recommendations, referrals, and a treatment/monitoring plan.

3. Clinical Interview: What to Ask

Presenting Concerns

- What prompted the evaluation now?
- Who first noticed the concern?
- What problems occur at home, school, work, relationships, driving, finances, chores, or self-care?
- What situations make symptoms better or worse?

Developmental History

- Pregnancy/birth complications when clinically relevant.
- Early developmental milestones.
- Temperament and early activity level.
- Preschool/elementary behavior and attention.
- History of repeated teacher comments, disciplinary problems, incomplete work, forgetfulness, disorganization, or excessive talking/movement.
- Academic progress, learning supports, IEP/504 history, retention, tutoring, and testing.

Current Symptom Examples

- Sustaining attention, listening, following through, organization, losing items, distractibility, forgetfulness.
- Fidgeting/restlessness, difficulty remaining seated, excessive activity or internal restlessness.
- Interrupting, impatience, acting before thinking, difficulty waiting.
- Time blindness, task initiation, procrastination, poor working memory, emotional reactivity, and inconsistent performance.

Strengths and Protective Factors

- Interests and areas of sustained attention.
- Relationships and supports.
- Creativity, persistence, humor, problem-solving, athletic or artistic strengths.
- Strategies the client already uses successfully.

4. Collateral Information

For children and adolescents, collateral information is especially important because symptoms and impairment should be understood across environments. Obtain releases when required.

- Parent/guardian report.
- Teacher or school staff report.
- School records, grades, discipline, attendance, IEP/504 documents, and prior psychoeducational testing.
- Prior therapist, pediatrician, psychiatrist, or other treating clinician records when relevant.
- For adults: partner/spouse or family collateral, childhood records, report cards, prior evaluations, or other evidence of longstanding symptoms when available.

When Reports Disagree

Do not simply average discrepant ratings. Explore context: structure, task demands, relationship dynamics, class size, medication timing, sleep, motivation, masking, and whether one setting provides more external support.

5. Rating Scales: How to Use Them

Use age-appropriate, validated tools that fit your scope, training, and licensing arrangements. Examples clinicians may consider include Vanderbilt scales for pediatric contexts, Conners measures, ADHD Rating Scale tools, and adult self-report measures such as the ASRS. Follow each instrument's official scoring and licensing rules.

Good Use of Rating Scales

- Collect from more than one informant when appropriate.
- Review item-level patterns, not only a total score.
- Compare symptoms with functional impairment.
- Use broad measures when anxiety, depression, behavior problems, trauma, autism, or other concerns are possible.
- Document the instrument name, informant, date, and clinical interpretation.

What Rating Scales Cannot Do

- They cannot independently prove ADHD.
- They cannot reliably determine the cause of concentration problems.
- A high score can occur with sleep deprivation, anxiety, depression, trauma, substance use, learning problems, or other conditions.
- A low score does not automatically rule out ADHD, especially when there is masking, strong structure, limited observation, or informant disagreement.

6. Assess Functional Impairment

Domain	Questions to Consider	Evidence / Examples
School/Work	Missed instructions? Late/incomplete work? Underperformance?	
Home	Chores, routines, organization, conflict, forgotten responsibilities?	
Social	Interrupting, missing cues, impulsive comments, inconsistent follow-through?	
Daily Living	Appointments, bills, driving, belongings, time management?	
Emotional	Frustration tolerance, shame, overwhelm, repeated failure experiences?	

7. Differential Diagnosis & Comorbidity Screen

Concentration problems are nonspecific. Always ask what else could produce the observed pattern.

Common Conditions to Consider

- Anxiety disorders - attention pulled toward worry or threat.
- Depressive disorders - slowed thinking, low motivation, poor concentration.
- Trauma/PTSD - hyperarousal, dissociation, intrusive memories, avoidance.
- Sleep disorders or insufficient sleep - fatigue, irritability, poor executive control.
- Learning/language disorders - task-specific avoidance or apparent inattention.
- Autism spectrum disorder - executive function and attention differences within a broader developmental profile.
- Oppositional defiant/conduct problems - distinguish inability from refusal or conflict-driven behavior.
- Bipolar disorder - episodic mood/energy changes rather than a stable developmental pattern.
- Substance use, medication effects, caffeine/energy products, or withdrawal.
- Medical contributors such as thyroid problems, seizure disorders, hearing/vision issues, or other conditions when clinically indicated.

Clinical Clue: ADHD vs. Anxiety

ADHD-related attention problems are often longstanding and occur even when the person is not worried. Anxiety-related inattention often increases when the person is preoccupied with threat, uncertainty, or physiological arousal. Both can coexist.

Clinical Clue: ADHD vs. Trauma

Ask about onset and timeline. Trauma-related concentration changes may begin or worsen after traumatic exposure and cluster with re-experiencing, avoidance, negative mood/cognition, or hyperarousal. ADHD requires a broader developmental pattern.

8. Child & Adolescent Assessment Structure

12. Parent/guardian interview.
13. Child/adolescent interview with developmentally appropriate language.
14. Teacher/school collateral and school records.
15. Parent + teacher rating scales when possible.
16. Screen emotional, behavioral, developmental, learning, sleep, and physical contributors.
17. Assess impairment in at least two meaningful settings.
18. Integrate developmental history and onset.
19. Feedback with caregiver and youth; explain strengths, needs, diagnosis/formulation, and recommendations.

Ask the Child Directly

- What is hardest about school?
- When is it easiest to focus?
- What do adults get wrong about you?
- What happens right before you get in trouble?
- What helps you get started or finish?
- How do you feel about yourself when these problems happen?

9. Adult ADHD Assessment Structure

- Establish evidence of a developmental pattern rather than only recent concentration problems.
- Review childhood school history, behavior, family recollections, old records, and prior diagnoses when available.
- Assess work history, education, relationships, parenting, finances, driving, household management, and time management.
- Screen mood, anxiety, trauma, sleep, substance use, medical factors, and medication effects.
- Explore compensatory strategies and masking - some adults function well only through extreme effort, rigid structure, or dependence on others.
- Consider whether symptoms are pervasive or occur mainly during high stress, burnout, depression, or sleep deprivation.

10. Optional Cognitive / Performance Testing

Neuropsychological or computerized attention testing may sometimes add useful information, but ADHD is not diagnosed by a single performance test. Testing is most useful when the referral question includes learning, cognitive, memory, intellectual, or complex differential-diagnostic concerns.

Do Not Overstate Testing
Normal performance on a structured attention task does not automatically rule out ADHD. Poor performance does not automatically confirm it. Interpret results in the context of the full evaluation.

11. Clinical Integration & Diagnostic Formulation

Formulation Template

Clinician Integration Note

Referral question: _____
Primary concerns: _____
Developmental/onset evidence: _____
Symptoms supported by interview: _____
Settings affected: _____
Functional impairments: _____
Collateral findings: _____
Rating-scale findings: _____
Differential diagnoses considered: _____
Comorbidities identified/suspected: _____
Medical/sleep/substance factors: _____
Strengths/protective factors: _____
Diagnostic conclusion / rationale: _____
Recommendations / referrals: _____

12. Feedback Session: How to Explain Results

- Start with strengths and the referral question.
- Explain what information was gathered and from whom.
- Describe the pattern rather than reading scale scores.
- Connect symptoms to real-world impairment.
- Explain differential diagnoses and any uncertainty.
- If ADHD is diagnosed, explain presentation and co-occurring conditions in plain language.
- If ADHD is not supported, clearly explain what appears to better account for the difficulties.
- Give prioritized recommendations rather than an overwhelming list.

MindLift Language

"The goal of an assessment is not to give you a label. It is to understand the pattern clearly enough that the next steps actually fit what you are experiencing."

13. Recommendations Menu

- Pediatrician/psychiatry or other qualified prescriber referral for medication evaluation when desired/appropriate.
- Behavioral parent training for younger children or families needing structured behavior support.
- CBT/executive-function skills work for organization, planning, procrastination, and emotional regulation.
- School accommodations/504 or special-education evaluation when indicated.
- Learning evaluation when academic skill deficits are suspected.
- Sleep evaluation/intervention when sleep problems are significant.
- Treatment of anxiety, depression, trauma, substance use, or other comorbid conditions.
- Organizational supports: visual schedules, timers, task breakdown, external reminders, body doubling, reduced distractions, consistent routines.

- Follow-up measurement to monitor response and functional outcomes.

14. Clinician Quick Checklist

☐ Referral question clarified

☐ Consent/assent completed

☐ Clinical interview completed

☐ Developmental history reviewed

☐ Symptoms assessed

☐ Impairment documented

☐ More than one setting assessed when required

☐ Collateral obtained/attempted

☐ Rating scales reviewed

☐ School/work records reviewed when available

☐ Sleep screened

☐ Medical/medication factors reviewed

☐ Anxiety/depression screened

☐ Trauma screened

☐ Learning/developmental concerns considered

☐ Substance use screened when age-appropriate

☐ Risk/safety assessed

☐ Differential diagnosis documented

☐ Comorbidities documented

☐ Feedback completed

☐ Recommendations/referrals provided

15. Documentation Language Example

“ADHD diagnostic impressions were based on an integrated review of clinical interview data, developmental history, reported functional impairment, collateral information, behavioral rating scales, and differential-diagnostic assessment. Rating-scale findings were interpreted as supportive data and not as a stand-alone diagnostic test.”

Professional References

- American Academy of Pediatrics. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents. Pediatrics. 2019;144(4):e20192528.
- Centers for Disease Control and Prevention. Clinical Care of ADHD in Children - Diagnosis and Evaluation.
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-5-TR). Use current diagnostic criteria within authorized clinical access.
- Use official manuals and licensing requirements for any standardized rating scale administered.