ADULT SELF-REPORT SCALE (ASRS) v1.2 SCREENING SCALE: A NEW SCREENER BASED ON DSM-5™

The ASRS v1.1 symptom checklist[22,23] was first developed by the World Health Organization, and contains 18 questions based on the 18 category A symptoms from the DSM-IV.[24] The ASRS v1.1 screening scale was developed from this and contains 6 of the 18 questions that were most predictive of ADHD, and these correspond to the 6 questions in part A of the full ASRS v1.1 symptom checklist.[22,23]

In 2017, the ASRS v1.1 screening scale was updated to ASRS v1.2 by revising the 6 DSM-IV questions to 4 questions based on the DSM-5™ (questions 1–4) and 2 non-DSM-5™ questions (questions 5 and 6).[25] The scale is short, easily scored and has been shown to correctly identify adults who meet the diagnostic criteria for ADHD in both the general population and in a speciality treatment setting.[25]

The patient answers the questions below, rating each of the criteria shown using the scale on the right side of the page. As they answer each question, they should place an X in the box that best describes how they have felt and conducted themselves over the past 6 months.[25]

	Never	Rarely	Sometimes	Often	Very often
1. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? (DSM-5™ A1c)	☐	☐	☐	☐	☐
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? (DSM-5™ A2b)	☐	☐	☐	☐	☐
3. How often do you have difficulty unwinding and relaxing when you have time to yourself? (DSM-5™ A2d)	☐	☐	☐	☐	☐
4. When you are in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish them themselves? (DSM-5™ A2g)	☐	☐	☐	☐	☐
5. How often do you put things off until the last minute? (Non-DSM)	☐	☐	☐	☐	☐
6. How often do you depend on others to keep your life in order and attend to details? (Non-DSM)	☐	☐	☐	☐	☐

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	