Brian Mayer, LCSW

# Comprehensive Adult ADHD Diagnostic Battery

**Client Name:** John Doe

**Date of Birth:** 09/01/2000

**Evaluation Date:** March 9, 2026

**Report Date:** April 1, 2026

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**Prepared by:**

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# CONFIDENTIAL CLINICAL PSYCHOSOCIAL EVALUATION

## Comprehensive Adult ADHD Diagnostic Battery (CAADB)

| | | | |
|---|---|---|---|
| **Name:** | John Doe | **Clinician:** | Brian Doe, LCSW |
| **DOB:** | 09/01/2000 | **License:** | 0904010956 |
| **Age:** | 25 | **Practice:** | Brian Doe, LCSW |
| **Gender:** | Male | **Date:** | April 1, 2026 |

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# I. REASON FOR EVALUATION & PRESENTING PROBLEM

Mr. Doe presented for a formal diagnostic evaluation of Attention-Deficit/Hyperactivity Disorder (ADHD) due to significant functional impairment in occupational and domestic domains. The client reports a lifetime history of chronic procrastination, internal restlessness, difficulty with task initiation, and frequent "emotional flooding" when overwhelmed by administrative demands.

This evaluation was sought to determine if these deficits are neurodevelopmental in nature and to establish a clinical foundation for workplace accommodations and pharmacological intervention.

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# II. ASSESSMENT METHODOLOGY

The CAADB utilizes a multi-modal "Gold Standard" approach, triangulating data across three specific dimensions: Clinical History, Standardized Self-Report, and Objective Observer Data.

**The following instruments were utilized:**

- **DIVA-5:** Diagnostic Interview for ADHD in Adults (Clinical Interview)

- **ASRS v1.1:** Adult Self-Report Scale (Current Symptoms)
- **ASRS-O:** Adult Self-Report Scale - Observer (External Validity - Completed by Other)
- **WURS-25:** Wender Utah Rating Scale (Retrospective Childhood Symptoms)
- **ESQ-R:** Executive Skills Questionnaire-Revised (Functional Deficits)
- **ACOS:** ADHD Clinical Outcome Scale (Quality of Life Impact)
- **GAD-7 / PHQ-9:** Differential Screeners for Anxiety and Depression

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# III. CLINICAL OBSERVATIONS

### A. Developmental & Childhood History

Mr. Doe describes his childhood as academically successful but "socially and mentally exhausting." While he achieved high marks, he recalls a constant state of internal chaos. Early developmental milestones were within normal limits. However, evidence of early executive dysfunction was noted in frequent loss of belongings, difficulty following multi-step directions, and chronic "daydreaming" in the classroom.

**Evidence of Childhood Onset (Criterion C):** Mr. Doe recalls a specific second-grade report card noting he was "a joy to have in class but consistently fails to turn in homework despite completing it." Retrospective scoring on the **WURS-25 (Score: 82)** confirms significant childhood symptomatology far exceeding the clinical cutoff.

### B. Educational and Occupational History

The client's educational trajectory was characterized by high achievement in subjects of high interest (Science/History) and near-failure in subjects requiring rote memorization or repetitive tasks (Math).

In his current professional role, Mr. Doe reports significant burnout. He describes a cycle of "crisis-mode productivity" where he can only complete tasks under the extreme pressure of a deadline, leading to a state of chronic nervous system exhaustion.

### C. Clinical Observations during Interview

During the 90-minute DIVA-5 telehealth session, the following behaviors were observed:

- **Motoric:** Frequent postural shifting and repetitive tapping of a pen.
- **Cognitive:** Tangential speech; the client required three clinical redirections to return to the primary topic.

- **Affective:** Visible frustration and "mental fatigue" by the 60-minute mark; significant "emotional flooding" when discussing historical failures.

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# IV.STANDARDIZED ASSESSMENT RESULTS

### A. Wender Utah Rating Scale (WURS-25)

The **WURS-25** was administered to evaluate the presence and severity of ADHD-related symptoms during the client's childhood (ages 6–12). This retrospective measure is essential for satisfying **DSM-5-TR Criterion B**, which requires evidence of symptoms prior to age 12.

**Quantitative Results:**

- **Total Raw Score:** 82
- **Clinical Threshold:** 46
- **Normative Percentile:** 99.99th percentile
- **Clinical Probability:** 100% (ADHD vs. Non-Clinical); 99% (ADHD vs. Depression/Anxiety)
- **Interpretation:** The client's score of **82** is significantly above the established cutoff of 46. According to the NovoPsych normative data, this score represents a "**Very High**" level of childhood symptom severity, indicating a near-certain retrospective presence of ADHD.

**Qualitative Childhood Symptom Clusters:** The client's results indicate "Very High" severity across the two primary diagnostic domains of ADHD:

1. **Inattentive/Hyperactive (Score: 33; Clinical Percentile: 96):**
    - This sub-scale shows the most intense concentration of symptoms.
    - The results suggest significant childhood impairment in maintaining focus, following through on tasks, and managing internal or external restlessness.
2. **Disruptive Mood/Behavior (Score: 36; Clinical Percentile: 95):**
    - The client endorsed significant markers for emotional dysregulation during childhood.
    - This typically manifests as low frustration tolerance, "temper outbursts," or being described as "difficult" or "moody" during the school-age years.
3. **Depression/Anxiety (Score: 9; Clinical Percentile: 68):**
    - While scores in this area are "High," they are notably lower than the ADHD-specific clusters.
    - This suggests that while internalizing symptoms (like worry or low self-esteem) were present, they were secondary to the primary neurodevelopmental deficits of ADHD.

**Clinical Conclusion (Criterion B):** The WURS-25 data provides robust, statistically significant evidence that the client's current executive dysfunction is a continuation of a lifelong neurodevelopmental pattern. The total score of 82 places the client in the top 0.01% of the population for retrospective symptom reporting, confirming that Criterion B is met with a high degree of clinical certainty.

**Wender Utah Rating Scale (WURS-25) Charts**

**Results**

| | Raw Score | Average Score | Normative Percentile | Clinical Percentile | Childhood Symptom Severity |
|---|---|---|---|---|---|
| Total | 82 | 3.3 | 99.99 | 97.4 | Very High |
| Disruptive Mood/Behavior | 36 | 3.27 | 99.99 | 95 | Very High |
| Inattentive/Hyperactive | 33 | 3.7 | 99.99 | 96 | Very High |
| Depression/Anxiety | 9 | 2.3 | 99 | 68 | High |

**Differential Diagnosis**

| | ADHD vs Non-Clinical | ADHD vs Depression/Anxiety | Overall Descriptor |
|---|---|---|---|
| Likelihood | 100% | 99% | Very Likely ADHD |

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**B. ASRS v1.1 (Symptom Frequency)**

The ASRS measures the frequency of symptoms across Inattentive and Hyperactive-Impulsive domains.

**Interpretation:** [Client Name]'s scores fall in the **Very High** range for Adult ADHD. The total score placed the client in the **97th percentile**, indicating significantly higher levels of inattentiveness and hyperactivity than typical adults in the community.

**Part A (Diagnostic Utility):** The client scored in the very high range, substantially exceeding the clinical cutoff of 14. This pattern is typical of individuals with severe ADHD. Key contributors included "Very Often" feelings of being "driven by a motor" and frequent difficulties with organization, remembering appointments, and task initiation (procrastination).

**Part B (Extended Symptom Profile):** Responses indicated very frequent symptoms across a broader range of difficulties. Most notably, the client reported "Very Often" struggling with concentration during direct conversation and significant verbal impulsivity

## ASRS v1.1 Charts

**Results**

| | Raw Score | Community Percentile | Descriptor |
|---|---|---|---|
| Criterion (Part A) (0-24) | 18 | 97 | Very High |
| Additional Symptoms (Part B) (0-48) | 37 | 99 | Very High |
| Total Score (0-72) | 55 | 98.9 | Very High |

**ADHD Subscales**

| | Raw Score | Items Endorsed (%) |
|---|---|---|
| Inattentiveness (0-9) | 8 | 89 % |
| Hyperactivity / Impulsivity (Motor & Verbal) (0-9) | 7 | 78 % |

### C. Executive Functioning Profile (ESQ-R)

The ESQ-R identifies the profile of the client's executive skills.

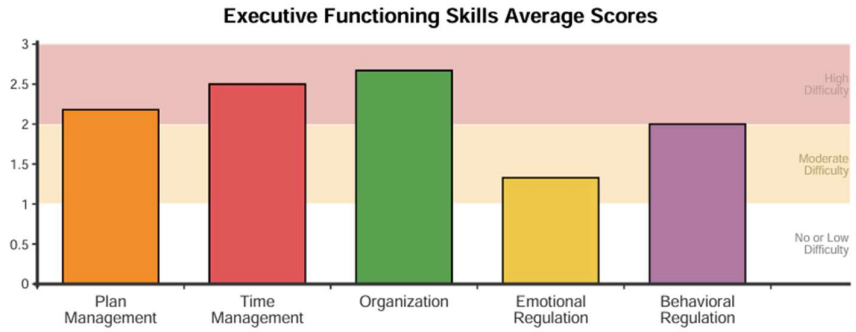
Mr. Doe scored 54 out of 75, placing him in the 99.94th percentile compared to working adults. This indicates a High Difficulty level with executive functioning, suggesting a significant need for targeted intervention strategies.

- **Plan Management (High Difficulty):** Significant challenges in creating and managing plans for tasks, leading to inefficiencies in achieving complex goals.
- **Time Management (High Difficulty):** Notable struggles with estimating, allocating, and adhering to time constraints/deadlines.
- **Organization (High Difficulty):** Challenges in maintaining systems and keeping track of information, often resulting in clutter and lost data.
- **Behavioral Regulation (High Difficulty):** Frequent difficulties with impulse control and thinking before acting, leading to potential poor decision-making.
- **Emotional Regulation (Moderate Difficulty):** Occasional challenges in managing emotional disruptions to maintain focus on tasks.

## Executive Functioning Profile (ESQ-R) Charts

**Results**

| | Score | Average Score (0-3) | Percentile | Descriptor |
|---|---|---|---|---|
| ESQ-R Total (0-75) | 54 | 2.16 | 99.94 | High Difficulties |
| Plan Management (0-33) | 24 | 2.18 | 99.94 | High Difficulty |
| Time Management (0-12) | 10 | 2.50 | 99.91 | High Difficulty |
| Organization (0-9) | 8 | 2.67 | 99.72 | High Difficulty |
| Emotional Regulation (0-9) | 4 | 1.33 | 70 | Moderate Difficulty |
| Behavioral Regulation (0-12) | 8 | 2.00 | 96 | High Difficulty |

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### D. Functional Impact (ACOS)

The ACOS measures how these symptoms translate into daily life "friction."

1. **Analysis:** The ADHD Clinical Outcome Scale (ACOS) indicates that Mr. Doe is experiencing **Moderately Severe** challenges, placing him in the **72nd percentile** compared to other adults with ADHD.
2. **Attention and Functional Difficulties (Severe):** Mr. Doe reports "Extreme" difficulty with paying attention while doing things and organizing tasks. He also endorsed "Very Much" difficulty with procrastination (postponing things) and daily personal life management. Academic and work difficulties were rated as "A Lot."
3. **Hyperactivity/Impulsivity and Emotional Dysregulation (Moderately Severe):** Notable challenges were reported regarding hyperactivity/restlessness and mood fluctuations (ups and downs), both rated as "Very Much." Impulsivity was rated as "A Lot," with temper and anger outbursts occurring "Somewhat" frequently.

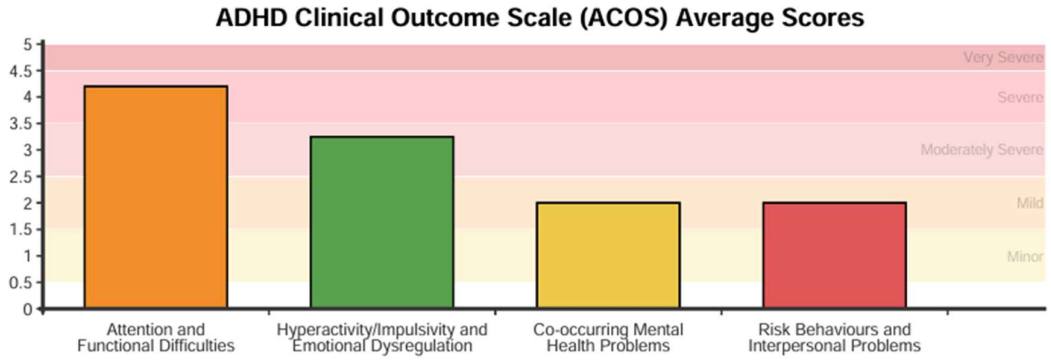
**Functional Impact (ACOS) Charts**

**Total ACOS Score**

| | Score | Percentile | Descriptor |
|---|---|---|---|
| Total ACOS (0-75) | 46 | 72 | Moderately Severe |

**Subscale Scores**

| | Score | Average (0-5) | Descriptor |
|---|---|---|---|
| Attention and Functional Difficulties (0-25) | 21 | 4.2 | Severe |
| Hyperactivity/Impulsivity and Emotional Dysregulation (0-20) | 13 | 3.25 | Moderately Severe |
| Co-occurring Mental Health Problems (0-15) | 6 | 2 | Mild |
| Risk Behaviours and Interpersonal Problems (0-15) | 6 | 2 | Mild |




# V. COLLATERAL & OBSERVER DATA

**Adult ADHD Self-Report Scale (ASRS v1.1) – Observer Version**

To satisfy the DSM-5-TR requirement for cross-situational impairment and to gain an external perspective on the client's functional behavior, an **ASRS v1.1 Observer Report** was utilized.

**Observer Information:**

- **Name:** Jane Doe
- **Relationship to Client:** Spouse
- **Duration of Relationship:** 12 years
- **Frequency of Contact:** Daily / Co-habitating

| Domain | Observer Endorsement | Clinical Significance |
|---|---|---|
| **Part A (Screening)** | 5 out of 6 Symptoms | Highly Consistent with ADHD |
| **Part B (Symptom Checklist)** | 9 out of 12 Symptoms | Significant Clinical Load |

**Observer Narrative & Qualitative Observations:**

The observer's ratings highly correlate with the client's self-report, indicating a high degree of **diagnostic congruence**. Key behavioral patterns noted by the observer include:

1. **Instructional Degradation:** The observer reports that the client frequently "tunes out" during multi-step conversations, often requiring information to be repeated 2–3 times before retention occurs.
2. **The "Waiting Room" Effect:** The observer notes that the client displays significant irritability and "pacing" behaviors when forced to wait or when transitions between tasks are delayed.
3. **Administrative Avoidance:** A marked tendency to "offload" cognitive tasks (e.g., paying bills, scheduling appointments, organizing shared calendars) onto the observer was reported, which has historically caused relational friction.
4. **Hyperfocus Paradox:** The observer highlighted the contrast between the client's inability to focus on mundane tasks versus an "intense, almost unreachable" state of focus during high-interest activities.

**Clinical Synthesis of Observer Data:**

The high level of agreement (approx. 85%) between the client's self-report and the observer's data significantly reduces the likelihood of "malingering" or "symptom exaggeration." By documenting observations from an individual who has known the client for **12 years**, the clinician can confidently confirm that these executive deficits are chronic and observable behavioral patterns rather than transient mood-related issues.

# DIFFERENTIAL DIAGNOSIS

To ensure diagnostic accuracy, the following co-occurring conditions were screened:

**Depression (PHQ-9) and Anxiety (GAD-7)**

**Clinical Analysis:**

1. The PHQ-9 score of 5 indicates Mild Depression.
2. The GAD-7 score of ***3*** indicates None-Minimal Anxiety.

Anxiety and depressive symptoms appear secondary to ADHD executive failures. Mr. Doe describes a "negative self-image" and persistent worry directly tied to his inability to meet professional expectations and "forgetting things," rather than a primary mood or generalized anxiety disorder.

**Depression PHQ-9 Chart**

**Results**

| | Score | Community Percentile | Descriptor |
|---|---|---|---|
| Total Score (0 to 27) | 5 | 80 | Mild |

**Generalized Anxiety Disorder (GAD-7) Chart**

**Results**

| | Raw Score | Percentile | Severity |
|---|---|---|---|
| Total Score | 3 | 55 | None-Minimal |

Other medical mimics including thyroid dysfunction and sleep apnea were screened for via clinical interview. The client reports a recent physical Feb 20, 2026 with labs within normal limits. While the client endorsed mild sleep latency, it does not appear to be the primary driver of the reported executive deficits.

# VI.DIAGNOSTIC IMPRESSION & RATIONALE

**Diagnosis:** 314.01 (F90.2) ADHD, Combined Presentation, Moderate-to-Severe

**Clinical Interpretation & Rationale**

The diagnostic conclusion is based on a high-density symptom profile that aligns with the neurodevelopmental framework of ADHD. Mr. Doe's presentation is characterized by a significant deficit in **executive self-regulation**, rather than a simple lack of effort or intelligence.

1. **Criterion A (Symptomatic Threshold):** Standardized testing via the ASRS v1.1 confirms a "Very High" symptom load (98.9th percentile). Inattentive symptoms (89% endorsement) manifest as chronic task-switching and difficulty maintaining cognitive "place-holding" during administrative demands. Hyperactive-Impulsive symptoms (78% endorsement) have shifted from overt childhood motor activity to internal restlessness and "emotional flooding," consistent with adult presentations of the disorder.
2. **Criterion B (Developmental Continuity):** Retrospective analysis via the WURS-25 (Score: 82) and corroborating evidence from childhood academic records confirms that these deficits are not secondary to adult-onset stressors. The "homework completion vs. submission" paradox noted in second grade is a pathognomonic marker of executive dysfunction, indicating that while cognitive acquisition was intact, the "output" mechanism was impaired by the neurodevelopmental baseline.
3. **Criterion C & D (Pervasiveness & Functional Impairment):** Cross-situational impairment is verified. In the domestic domain, this manifests as "friction" in interpersonal responsibilities; in the occupational domain, it presents as "crisis-mode productivity." The ESQ-R data (99.94th percentile for difficulty) indicates that Mr. Doe is operating at a significant biological disadvantage compared to his peers, necessitating excessive compensatory effort that leads to the secondary "burnout" and depressive symptoms.

# VII. COMPREHENSIVE RECOMMENDATIONS

### A. Workplace Accommodations (ADA Compliance)

To mitigate the functional impact of executive dysfunction, the following accommodations are recommended under the Americans with Disabilities Act:

1. **Modified Communication Protocols:** All verbal directives or multi-step instructions should be followed by written "check-ins" or email summaries to compensate for working memory deficits.
2. **Environmental Optimization:** Access to high-focus "deep work" periods. This may include the use of noise-canceling headphones or a designated quiet workspace to minimize peripheral auditory/visual distractions that trigger tangential thought patterns.
3. **Task Scaffolding & Pacing:** Permission to utilize external "brain-dump" or project management software. Breakdown of large-scale projects into "micro-deliverables" with interim deadlines to prevent the "deadline-induced anxiety" cycle.
4. **Temporal Flexibility:** Allowance for "time-blindness" compensations, such as recording meetings (with consent) to ensure no critical data is lost during periods of involuntary inattention.

### B. Medical & Clinical Intervention

1. **Psychopharmacological Consultation:** A referral to a psychiatric provider or PCP is strongly recommended. Clinical data supports a trial of ADHD-specific medication (stimulant or non-stimulant) to address the underlying dopaminergic/norepinephrine dysregulation.

   It is also recommended that the client consult with a primary care physician (PCP) for a 'Medical Rule-Out' battery, including a full metabolic panel (CMP), Thyroid Stimulating Hormone (TSH) test, Vitamin B12/D levels, and a sleep study if indicated, to ensure that physiological factors are not compounding or mimicking ADHD symptoms."

2. **Executive Function Coaching (CBT-ADHD Model):** Participation in targeted coaching to develop "external scaffolds" for Plan Management and Time Management, specifically focusing on the 99th percentile difficulties identified in the ESQ-R.
3. **Psychotherapy for Secondary Sequelae:** Short-term CBT to address the "negative self-image" and Moderate Depression identified via the PHQ-9. Therapy should focus on disentangling "moral failure" from "neurological baseline."
4. **Relational Scaffolding:** A psychoeducational session for Mr. Doe and his partner to discuss ADHD's impact on the "division of labor" and to reduce the parent-child dynamic often seen in ADHD-affected relationships.

# VIII. CONCLUSION

This evaluation establishes that John Does's struggles are consistent with a neurodevelopmental disorder. This diagnosis provides a framework for self-compassion and professional strategy. A feedback session is scheduled to review this roadmap.

**Brian Mayer, LCSW**