

BAARS-IV: Self-Report: Childhood Symptoms

Name: _____ Date: _____

Sex: (Circle one) Male Female Age: _____

Instructions

For the first 18 items, please circle the number next to each item below that best describes your behavior when you were a child **BETWEEN 5 AND 12 YEARS OF AGE**. Then answer the remaining two questions. Please ignore the sections marked "Office Use Only."

	Never or rarely	Some- times	Often	Very often
Section 1 (Inattention)				
1. Failed to give close attention to details or made careless mistakes in my work or other activities	1	2	3	4
2. Had difficulty sustaining my attention in tasks or fun activities	1	2	3	4
3. Didn't listen when spoken to directly	1	2	3	4
4. Didn't follow through on instructions and failed to finish work or chores	1	2	3	4
5. Had difficulty organizing tasks and activities	1	2	3	4
6. Avoided, disliked, or was reluctant to engage in tasks that required sustained mental effort	1	2	3	4
7. Lost things necessary for tasks or activities	1	2	3	4
8. Was easily distracted by extraneous stimuli or irrelevant thoughts	1	2	3	4
9. Was forgetful in daily activities	1	2	3	4
Office Use Only (Section 1)				
Total Score _____ Symptom Count _____				
Section 2 (Hyperactivity–Impulsivity)				
10. Fidgeted with my hands or feet or squirmed in my seat	1	2	3	4
11. Left my seat in classrooms or in other situations in which remaining seated was expected	1	2	3	4
12. Shifted around excessively or felt restless or hemmed in	1	2	3	4
13. Had difficulty engaging in leisure activities quietly (felt uncomfortable, or was loud or noisy)	1	2	3	4
14. Was "on the go" or acted as if "driven by a motor"	1	2	3	4
15. Talked excessively	1	2	3	4

BAARS-IV: Self-Report: Childhood Symptoms (page 2 of 2)

16. Blurted out answers before questions had been completed, completed others' sentences, or jumped the gun	1	2	3	4
17. Had difficulty awaiting my turn	1	2	3	4
18. Interrupted or intruded on others (butted into conversations or activities without permission or took over what others were doing)	1	2	3	4
Office Use Only (Section 2)				
Total Score _____ Symptom Count _____				
Sum of Sections 1-2 for Total Scores _____				
Sum of Sections 1-2 for Symptom Counts _____				

Section 3

19. Did you experience *any* of these 18 symptoms at least "Often" or more frequently (Did you circle a 3 or a 4 above)? **No** **Yes** (Circle one)
20. If so, in which of these settings did those symptoms impair your functioning? Place a *check mark* (✓) next to all of the areas that apply to you.
- _____ School
- _____ Home
- _____ Social Relationships

Note. Items 1-18 are adapted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Copyright 2000 by the American Psychiatric Association.