24-7 SHALOM PSYCHIATRY PLLC

Comprehensive Adult ADHD Evaluation, Diagnosis & Treatment Program

Clinical program framework | Adults age 18 and older

This document describes an evidence-informed program that 24-7 Shalom Psychiatry PLLC may implement for adults presenting with suspected or established attention-deficit/hyperactivity disorder (ADHD). It is a clinical service framework, not a statement that every listed test or intervention is currently offered. Specialized services require qualified personnel, appropriate licensing, equipment, and referral arrangements.

1 | Clinical objectives and presenting concerns

Adult ADHD may involve persistent inattention, impulsivity and/or restlessness that impair occupational performance, education, relationships, household responsibilities, driving, financial organization and emotional well-being. The evaluation examines functional impairment rather than equating a positive screening score with a diagnosis.

- Inattention: distractibility, forgetfulness, losing items, careless errors, incomplete tasks and difficulty following detailed instructions.
- Executive dysfunction: poor prioritization, procrastination, inconsistent task initiation, time blindness, working-memory difficulties and disorganization.
- Hyperactivity/impulsivity: internal restlessness, excessive talking, interrupting, impatience, impulsive decisions and difficulty remaining seated.
- Strengths and adaptations: assess compensatory routines, interests, occupational demands, supports and existing coping strategies.

2 | Stepwise comprehensive diagnostic evaluation

- Pre-visit intake: chief concerns, goals, past treatment, medication and substance history, medical problems, sleep, psychosocial context and available school/occupational records.
- Diagnostic interview: assess each DSM-5-TR symptom with concrete current and childhood examples; document frequency, persistence, severity and consequences.
- Developmental corroboration: seek evidence of symptoms before age 12 through history, report cards, previous evaluations or collateral reports when available and authorized.
- Cross-setting impairment: establish symptoms in two or more settings and functional interference; explore home, employment, education and relationships.
- Standardized measures: use appropriate adult scales to support, not replace, clinical diagnosis.
- Psychiatric/medical differential: investigate alternative explanations, comorbidity and treatment safety.
- Feedback and shared planning: explain diagnostic conclusions, uncertainties, options, risks and follow-up; document informed decisions.

3 | DSM-5-TR ADHD diagnostic framework

Element	Adult diagnostic standard
Symptoms	At least 5 inattentive and/or 5 hyperactive-impulsive symptoms for age 17+
Duration	Persistent at least 6 months and inconsistent with developmental level
Onset	Several symptoms present before age 12
Settings	Several symptoms present in at least 2 settings
Impact	Clear evidence symptoms interfere with or reduce quality of social, academic or occupational functioning
Exclusions	Not exclusively during schizophrenia/other psychotic disorder and not better explained by another mental disorder

Presentations: predominantly inattentive (F90.0), predominantly hyperactive/impulsive (F90.1), combined (F90.2). Other specified (F90.8) or unspecified (F90.9) may be appropriate when clinically justified. Document current presentation, severity (mild/moderate/severe) and partial remission when applicable; verify coding for the encounter.

4 | Assessment instruments and advanced testing

Tool	Appropriate role
ASRS-v1.1 / ASRS-5	Screening and symptom tracking; positive result does not establish ADHD
DIVA-5 / ACE+ / CAADID	Structured or semi-structured adult diagnostic interviews
CAARS 2 / BAARS-IV / Brown EF/A	Multi-domain symptom assessment; self- and observer reports as appropriate
BRIEF2A / functional impairment scales	Everyday executive function and impairment across roles
Wender Utah Rating Scale	Retrospective childhood symptoms; recall limitations apply
QbTest, TOVA, CPT-3, IVA-2	Optional computerized attention/performance measures; not stand-alone diagnostic tests
Neuropsychological testing	Selective referral for learning disorder, complex cognition, neurologic injury or diagnostic uncertainty

Use licensed tools according to publisher requirements and clinician qualifications. Neuropsychological testing, EEG, imaging and laboratory panels are not routinely required to diagnose uncomplicated ADHD. A normal continuous-performance test does not rule it out.

5 | Differential diagnosis and co-occurring conditions

- Mood and anxiety: major depression, generalized anxiety, bipolar disorder, trauma-related symptoms, OCD and adjustment disorders. Assess episodic versus lifelong symptoms.

- Sleep and medical: sleep deprivation, obstructive sleep apnea, thyroid dysfunction, anemia, medication effects, hearing/vision impairment and neurological conditions when suggested by history.
- Substance use: alcohol, cannabis, sedatives, stimulants and other substances; consider intoxication, withdrawal and misuse risk.
- Neurodevelopmental/cognitive: autism spectrum disorder, specific learning disorder, intellectual disability and neurocognitive disorders where relevant.
- Safety: assess suicidal ideation, self-harm, mania, psychosis, unsafe driving and other clinically relevant risks; document actual findings rather than presumed negatives.

Potential adjunctive scales include PHQ-9, GAD-7, PCL-5, MDQ, AUDIT-C, DAST-10 and sleep questionnaires when indicated. Testing should follow the clinical question, not an automatic universal panel.

6 | Individualized treatment: medication

Medication selection considers symptom burden, impairment, previous response, comorbidities, cardiovascular and psychiatric history, patient preferences, cost and diversion risk. Stimulants are often first-line pharmacotherapy for adults when clinically appropriate; nonstimulants provide alternatives.

Class / examples	Benefits and common or important adverse effects
Methylphenidate / dexmethylphenidate (e.g., Concerta, Ritalin, Focalin)	May improve attention and inhibition. Appetite suppression, insomnia, headache, nausea, irritability, increased pulse/BP; rare serious psychiatric or cardiac events.
Amphetamine formulations / lisdexamfetamine (e.g., Adderall XR, Vyvanse)	May improve attention and task completion. Reduced appetite, insomnia, dry mouth, anxiety, elevated pulse/BP; misuse/dependence risk and rare serious adverse effects.
Atomoxetine	Noncontrolled option. Nausea, dry mouth, appetite reduction, fatigue or insomnia, sexual adverse effects; monitor BP/HR, rare liver injury, and suicidality warning in children/adolescents.
Viloxazine ER	Noncontrolled option. Nausea, decreased appetite, fatigue, insomnia, increased HR/BP; suicidality warning and clinically important drug interactions.
Guanfacine ER / clonidine ER	Adult ADHD use is off-label in the US. Sedation, dizziness, hypotension, bradycardia; avoid abrupt discontinuation due to rebound hypertension.
Bupropion (off-label)	May be considered in selected adults. Insomnia, anxiety, dry mouth, BP elevation; seizure risk and contraindications must be reviewed.

Before and during treatment, assess BP, pulse, weight, sleep, appetite, mood, adverse effects, adherence and response. Review cardiovascular history and family history; ECG/cardiology assessment when clinically indicated rather than universally. Follow applicable DEA, state, PDMP and telehealth requirements for controlled medications. Avoid automatic or unsupported prescribing promises.

7 | Psychotherapy, coaching and behavioral treatment

- ADHD-focused CBT: target procrastination, avoidance, self-critical beliefs, organization, planning and behavioral follow-through.

- Executive-function skills: calendar and reminder systems, time blocking, task breakdown, external cues, structured routines and environmental modifications.
- Motivational and acceptance-based approaches: support goal-directed action and engagement where appropriate; tailor to co-occurring concerns.
- Sleep and lifestyle: regular sleep-wake schedule, physical activity, nutrition and minimizing substances that impair sleep or concentration.
- Relationship interventions: psychoeducation, communication strategies and couples/family work when clinically indicated.
- Coaching: practical support for accountability and routines; an adjunct, not a substitute for clinical treatment.

8 | Occupational, academic and life-function support

With consent and clinical justification, provide documentation of diagnosed impairments and recommended functional accommodations. Options may include written instructions, quiet work areas, structured deadlines, scheduled breaks, assistive technology and task-management systems. Employers, institutions and testing organizations determine eligibility under their governing rules. Support strategies also address household management, budgeting, driving, parenting and relationship functioning.

9 | Measurement-based monitoring and follow-up

- Record baseline symptoms, functional goals, rating scales, vital signs and treatment preferences.
- During titration, review symptom benefit, duration of coverage, sleep, appetite, cardiovascular effects, mood and adherence; adjust only when clinically indicated.
- Repeat a consistent rating scale and functional measures to track meaningful change, not merely test scores.
- Once stable, schedule periodic reassessment of efficacy, adverse effects, comorbidities, safety, diversion risk and continued need for treatment.
- Reconsider diagnosis and treatment plan when response is poor, adverse effects emerge or new information changes the clinical formulation.

10 | Telepsychiatry, quality and documentation

Remote visits may support clinical interviews, rating scales, collateral history, psychoeducation, psychotherapy and follow-up where clinically appropriate. In-person assessment or specialist referral is used when examination, complex testing or safety considerations require it. Controlled-substance teleprescribing must meet current federal and state requirements.

Each encounter should document the presenting complaint, developmental evidence, DSM-5-TR criteria, functional impairment, differential diagnosis, risk assessment, observed mental status, tests reviewed, treatment rationale, informed decisions, medication details, counseling actually provided, monitoring and follow-up. Never document an assessment or intervention that was not performed.

11 | Practice implementation checklist

- Adopt a standardized adult intake, diagnostic interview template and functional-impairment assessment.

- License selected scales and train clinicians in administration, scoring and interpretation.
- Establish referral partnerships for neuropsychology, sleep medicine, cardiology and complex diagnostic assessment.
- Create medication safety, controlled-substance, PDMP and follow-up workflows aligned with current laws.
- Audit diagnostic documentation, treatment outcomes, patient experience and adverse-event monitoring.

Patient-facing description

At 24-7 Shalom Psychiatry PLLC, our Adult ADHD program focuses on understanding the whole person. We evaluate persistent challenges with attention, organization, time management, impulsivity and executive functioning, including their effects on work, relationships and daily life. Our assessment integrates a detailed clinical interview, developmental history, DSM-5-TR criteria, validated symptom measures and evaluation for conditions that may overlap with ADHD. Treatment recommendations may include medication management, ADHD-focused psychotherapy, practical organizational strategies and ongoing progress monitoring. Specialized testing or referrals are arranged when clinically appropriate. Our goal is to support meaningful, measurable improvements in everyday functioning.

Selected clinical references

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR).

National Institute for Health and Care Excellence. (2018, updated). Attention deficit hyperactivity disorder: diagnosis and management (NG87).

Centers for Disease Control and Prevention. Diagnosing ADHD; Treatment of ADHD. https://www.cdc.gov/adhd/

U.S. Food and Drug Administration. Prescribing information and medication guides for ADHD medications; consult current product labeling. https://www.accessdata.fda.gov/scripts/cder/daf/

Clinical education and proposed operational framework. Individual care requires professional judgment, current product labeling, and applicable laws. No practice contact information or address is included in the header.