ADHD — Recognition & Diagnostic Criteria

Three presentations, DSM-5-TR criteria & severity

CLINICAL PATHWAY

All five criteria (A–E) must be met — not just a symptom count. Persistent inattention and/or hyperactivity-impulsivity before age 12, in ≥2 settings, causing real functional impairment: ≥6 symptoms if under 17, ≥5 if 17 or older, for ≥6 months.

THREE DSM-5-TR PRESENTATIONS

- **Predominantly inattentive:** careless mistakes, poor sustained attention, doesn't listen when spoken to, fails to finish tasks, disorganised, avoids sustained mental effort, loses things, easily distracted, forgetful
- **Predominantly hyperactive-impulsive:** fidgets/squirms, leaves seat when expected to remain seated, runs/climbs inappropriately, talks excessively, blurts answers, can't wait turn, interrupts others
- **Combined:** meets full criteria for both dimensions — the most common presentation, and the one most likely to prompt formal assessment

SEVERITY (DSM-5-TR)

- **Mild:** few symptoms beyond threshold; minor impairment in only 1–2 settings
- **Moderate:** symptoms and impairment between mild and severe; noticeably affecting daily function
- **Severe:** many symptoms well beyond threshold; marked impairment across multiple settings — work, home, social, self-care

DIAGNOSTIC CRITERIA (A-E)

All five must be satisfied — none is optional.

A	**Symptoms:** ≥6 inattention or hyperactivity-impulsivity symptoms (under 17) or ≥5 (17 and over), for ≥6 months
B	**Onset:** several symptoms present before age 12 — needs retrospective history; old school reports are invaluable
C	**Pervasiveness:** symptoms in ≥2 settings (school, home, work, social) — collateral history is essential
D	**Impairment:** clear functional interference in academic, occupational or social domains — without impairment, no diagnosis
E	**Exclusions:** not occurring exclusively during psychosis, autism or another disorder, and not better explained by substance use or a medical condition

FULL DSM-5-TR TEXT & CODING

This sheet summarises the recognition framework — it is not a substitute for the full DSM-5-TR criteria or the Australian Evidence-Based Clinical Practice Guideline for ADHD (AADPA, 2022) at adhdguideline.aadpa.com.au. A formal diagnosis is made by a psychiatrist or paediatrician, not in general practice.

■ SAFETY

- Don't diagnose from a symptom count alone — all five criteria (A–E) must be met, including onset before age 12 and impairment in at least two settings
- Collateral history (family, partner, old school reports) is often the only reliable evidence for Criterion B — self-report alone is not enough
- Don't attempt a formal ADHD diagnosis in general practice — this requires specialist assessment

■ RED FLAGS / REFER

- Recognition criteria appear to be met → proceed to screening and the referral pathway (MH-01B)
- Comorbid mental health features present → screen alongside referral (MH-01C)
- Suspected autism, learning disability, or treatment being considered → see pre-treatment workup (MH-01D)