SAMPLE DOCUMENT. Fictional client. For illustration of format and scope only.

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Comprehensive Diagnostic Evaluation Report

Adult Autism Spectrum and ADHD Evaluation (Combined)

Client	J. Doe (fictional)
Date of birth	01/01/1994 (age 32)
Evaluation date	November 20, 2026
Report date	November 24, 2026
Evaluator	Alison D. Mitchell, MD, Licensed Psychiatrist (LA, CA)
Format	Secure video telehealth; client located in Louisiana
Referral question	Self-referred. "I think I might be autistic, and I've always struggled with focus. I want to know what's going on and what would help."

1. Summary of findings

Diagnoses: Autism Spectrum Disorder, Level 1 (requiring support), without intellectual or language impairment (F84.0); Attention-Deficit/Hyperactivity Disorder, combined presentation, moderate (F90.2); Generalized Anxiety Disorder (F41.1), judged secondary to the above.

Ms. Doe meets full DSM-5-TR criteria for Autism Spectrum Disorder and for ADHD, combined presentation. Both are supported by a convergent pattern across the structured developmental interview, self-report instruments, objective computerized attention testing, and clinical observation. Her anxiety is best understood as a downstream consequence of years of masking and of unrecognized executive-function demands rather than as a primary disorder. Functional impact is significant in sustained work performance, social energy, and daily organization. Specific recommendations and accommodations are listed in Sections 7 and 8.

2. Sources of information

- Structured developmental and social history questionnaire completed by the client before the session (written responses and three voice notes).
- Clinical interview by secure video, 60 minutes, conducted by Dr. Mitchell, following a MIGDAS-2-informed sensory and social interview structure.
- Self-report instruments: RAADS-R, Autism Spectrum Quotient (AQ-50), Camouflaging Autistic Traits Questionnaire (CAT-Q), Adult ADHD Self-Report Scale (ASRS v1.1), GAD-7, PHQ-9.
- Objective testing: FDA-cleared computerized continuous performance test of attention, impulsivity and activity, administered remotely.

- Collateral: none obtained. The client declined the optional informant interview; childhood report cards (grades 2 through 6) were reviewed.
- Clinical observation during the video session.

3. Background and developmental history

Ms. Doe is a 32-year-old software quality analyst, single, living alone, with a bachelor's degree completed in six years. She reports being a quiet, rule-bound child who read far above grade level, had one close friend at a time, and was described by teachers as "in her own world" and "capable of so much more." Report cards from grades 2 through 6 note "does not complete work," "daydreams," and "excellent reader" in every year reviewed. She was never evaluated in childhood. She describes a long history of intense interests pursued to exhaustion (marine biology at 8, a single video game franchise from 12 to 19, now database architecture), strong sensory sensitivities to fluorescent light and overlapping conversation, and a need for predictable routines that, when disrupted, produces shutdowns lasting hours. She began consciously studying and copying peers' social behavior around age 13 and describes social events as "a performance I have to recover from for two days." Academically she performed well on exams and poorly on sustained projects, lost two jobs to missed deadlines, and has been treated for anxiety with an SSRI since age 26 with partial benefit. No history of psychosis, mania, substance use disorder, head injury, or seizure. Family history is notable for a brother diagnosed with ADHD at 9 and a father the client describes as "obviously autistic, never diagnosed."

4. Instrument results

Instrument	Score	Threshold	Interpretation
RAADS-R	142	65 or higher suggests autism	Well above threshold; highest on social relatedness and sensory-motor subscales
AQ-50	38	32 or higher suggests autism	Above threshold; elevated on attention switching, communication, imagination
CAT-Q	148	100 or higher suggests significant camouflaging	High masking; compensation and assimilation subscales most elevated
ASRS v1.1 Part A	5 of 6	4 or more suggests ADHD	Positive screen; inattentive items endorsed as very often
Computerized CPT	Attention and impulsivity both above 90th percentile for age and sex; activity at 78th percentile	Normative comparison	Objective evidence of inattention and impulsivity consistent with ADHD, combined presentation
GAD-7	14	10 or higher moderate	Moderate anxiety
PHQ-9	9	10 or higher moderate	Mild depressive symptoms, no suicidal ideation

Self-report instruments are screening measures and are interpreted alongside history and observation, not in isolation. The computerized test provides objective, normed data on attention and impulse control and does not by itself diagnose or exclude ADHD.

5. Clinical observation

On video Ms. Doe was well groomed, articulate, and precise in her language, often correcting her own word choices for accuracy. Eye contact was intermittent and effortful; she stated she was "looking at the camera because I know I'm supposed to." Prosody was somewhat flat with limited range. She answered open questions with highly detailed, chronological accounts and needed redirection on three occasions to return to the question asked. She lost her thread twice mid-sentence and apologized each time. Affect was anxious but appropriate. She fidgeted with a pen throughout and shifted position frequently. Humor was present and literal. Insight and judgment were intact. No evidence of thought disorder, perceptual disturbance, or mood elevation.

6. Diagnostic formulation

Autism Spectrum Disorder (DSM-5-TR)

A. Persistent deficits in social communication and interaction. A1 reciprocity: reports one-sided conversations about interests, difficulty with small talk, and not knowing when a conversation is over. A2 nonverbal communication: effortful eye contact, flat prosody, and reports that others read her as "cold" or "bored" when she is not. A3 relationships: one friend at a time through childhood, difficulty adjusting behavior across contexts, no current close friendships outside her brother.

B. Restricted, repetitive patterns. B1: hand flapping and rocking when excited or distressed, reported since childhood and observed briefly in session. B2: distress at schedule changes producing hours-long shutdowns. B3: highly restricted, intense interests pursued to the exclusion of sleep and meals. B4: hypersensitivity to fluorescent light and overlapping sound; hyposensitivity to hunger cues.

C, D, E. Symptoms present in early childhood by history and school records; cause clinically significant impairment in occupational and social functioning; not better explained by intellectual disability or global developmental delay. Level 1 is assigned: she requires support, particularly with social communication and transitions, but lives and works independently.

ADHD, combined presentation (DSM-5-TR)

Six of nine inattentive criteria (fails to give close attention, difficulty sustaining attention, does not follow through, difficulty organizing, avoids sustained mental effort, easily distracted) and six of nine hyperactive-impulsive criteria (fidgets, leaves seat, restless, talks excessively, blurts answers, interrupts) are met, with onset before age 12 documented in school records and present across home and work. Objective testing corroborates inattention and impulsivity. Symptoms are not better explained by autism alone: the executive dysfunction extends to interest areas as well as non-preferred tasks, and the impulsivity pattern is independent of sensory load.

Differential and co-occurring conditions

Social anxiety was considered; however, the social difficulties pre-date anxiety, persist with trusted people, and are accompanied by sensory and restricted-interest features that social anxiety does not explain. A personality disorder was considered and not supported: interpersonal patterns are consistent, non-manipulative, and attributable to communication differences. Generalized Anxiety Disorder is diagnosed as a co-occurring condition and is judged largely secondary to masking load and executive demands. No evidence of bipolar spectrum disorder, psychotic disorder, or substance use disorder.

7. Recommendations

- Medication: a trial of a long-acting stimulant for ADHD is appropriate and may reduce the executive-function load that is driving anxiety. This can be initiated in this practice with

monitoring, or coordinated with her current prescriber. Review the SSRI after stimulant response is established.

- Psychoeducation: a structured post-diagnosis program covering sensory regulation, energy accounting, unmasking safely, and executive-function systems.
- Therapy: neurodiversity-affirming individual therapy, with CBT adapted for autistic adults, focused on burnout prevention and self-advocacy rather than social-skills correction.
- Environment: fixed-schedule work where possible, written rather than verbal instructions, control over lighting and sound, and predictable transitions.
- Sleep: a fixed sleep window and a wind-down routine; reassess once stimulant timing is settled.
- Re-evaluation: this report remains current for three years for most accommodation purposes. A brief re-attestation is available thereafter.

8. Recommended accommodations

The following are functionally linked to the diagnoses above and are appropriate for workplace, academic or standardized-testing settings:

- Extended time (50%) on timed assessments, linked to documented processing and attention differences.
- A separate, low-distraction testing or working environment with control over lighting and sound.
- Written instructions and written confirmation of verbal directions; advance notice of schedule changes.
- Scheduled breaks during sustained tasks or examinations.
- Flexibility in camera-on requirements and non-essential social events.

9. Limitations

This evaluation was conducted by secure video. Some nonverbal features, including fine-grained eye-contact behavior, are less reliably assessed remotely. No informant interview was obtained; childhood presentation relies on client recall and school records. Self-report instruments are subject to response bias and are not diagnostic alone. This report does not constitute a full neuropsychological evaluation and does not assess for learning disorders or intellectual functioning. A decision to grant any accommodation rests solely with the receiving institution or agency.

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Signed electronically on November 24, 2026