WURS_____
PRS _____

Pre-Assessment History Form

Note that any information provided here is strictly confidential

Instructions: The following form is developed to assist us in gaining information about your early history and reasons for seeking help. Please answer the questions to the best of your ability. It is sometimes helpful to ask your family members for events that happened some time ago. When you have completed the form, please return it to the Counseling & Testing Center.

Last Name:_____ First Name: _____ Middle Initial:_____

Today's Date:_____ Date of Birth:_____ Age: _____

Email:_____ Phone#_____

Year in School: ____Freshman ____Sophomore ____Junior ____Senior ____Grad/Law

What is your major? _____ How many credits are you currently taking ____

What is your current GPA ____ Student ID # _____

Who referred you to the CTC for assessment?_____
(note: referrals from DSS, Dr. Cone and from within the CTC will receive priority)

Please describe any problems you are currently experiencing that are related to why you are seeking help now. Try to be specific.

Please check any of the following that you feel are more problematic for you than for your peers.

___ Understanding what you read
___ Reading speed
___ Pronouncing new words
___ Math calculation
___ Math reasoning
___ Story problems
___ Expressing thoughts in writing
___ Spelling
___ Grammar / punctuation
___ Attention / Hyperactivity
___ Memory
___ Drugs/alcohol
___ Depression
___ Anxiety

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School History

During grade school, did you have any social problems: ____yes ____no

did you get in trouble more than others? ____yes ____no

did you have any academic problems? ____yes ____no

During junior high/high school, did you have any social problems: ____yes ____no

did you get in trouble more than others? ____yes ____no

did you have any academic problems? ____yes ____no

How were your grades in grade school: ____Average ___Above average ___Below Average

How were your grades in high school: ____Average ___Above average ___Below Average

Were you ever in any special classes in school? ____yes ____no
If yes, please describe::

Did you ever repeat a grade? ____yes ____no
If yes, which grade(s)

_____

What were your easiest subjects for you in school? _____
(or favorite)

_____

What were the hardest subjects for you in school? _____
(or least favorite)

_____

Did you ever skip school without a valid reason? ____yes ____no
If yes,

How often?	What Grade(s)	What did you do when you skipped?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the schools you have attended and what years/grades you attended:

_____
_____
_____
_____
_____
_____

Note that any information provided here is strictly confidential

Did you ever run away from home overnight? ____yes ____no

Were you ever expelled or suspended from school? ____yes ____no

Did you ever get into any physical fights at school? ____yes ____no

Have you ever been in trouble for stealing or damaging property? ____yes ____no

Have you ever been arrested or in trouble with the law? ____yes ____no:

Do you have a driver's license? ____ yes ____ no

If yes

How many traffic tickets, other than parking tickets, have you had? _____

How many accidents have you been in where you were driving? _____

Have you ever been diagnosed with a learning disability, AD/HD or a psychiatric condition? ____yes ____no

If yes, Please indicate diagnosis, when it was made, who diagnosed you and the treatment administered

_____

_____

_____

_____

_____

Family

Please give the ages and relationships of persons in your immediate family, including parents, siblings, children and spouse. Opposite each name, list any difficulties you are aware of such as depression, anxiety, anger, interpersonal, alcohol/drugs, learning disabilities, AD/HD etc.

Relationship	Age	List any difficulties you know of:

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Family Relationships

Describe what your household was like when you were growing up. Be sure to include any significant events (deaths, divorce, moves, etc). Describe what your current family relationships are like, both with your original family and your current family. How do they compare with the family relationships of your peers?

Medical History

Describe any serious illnesses, accidents, diseases or medical conditions that you are currently or have ever suffered from. Have you ever lost consciousness from a head injury or fever?

Medications

List any medications you are currently taking, including the dosages.

Name of Medication	Dosage	Condition for which it is taken	When Taken

Do you smoke? ____ Yes ____ No If yes, how much?_____ Packs per day

How many caffeinated beverages do you drink in a day (on average)? (one beverage = 1 cup of coffee, 1 can of pop, 1 cup of tea)

____ None ____ 1-2 ____ 3-4 ____ 5-6 ____ 7 or more

On average, how often do you drink alcohol? ____ Seldom/never ____ Once a week or less

____ 2-3 times per week ____ 4 or more times per week

If you drink alcohol, how much do you usually consume at one time (i.e., one evening)?

____ One drink (one mixed drink, beer or glass of wine) or less ____ 2-3 drinks

____ 4-5 drinks ____ 6-7 drinks ____ 8-10 drinks ____ More than 10 drinks

What do you usually drink? _____

Do you or have you used drugs recreationally? ____ Yes ____ No
If Yes, please complete the following:

Name of Drug(s)	Frequency of use	When used (approx.)

Do you think you have a problem with drinking or drugs, now or in the past? ____ No ____ Yes
If Yes, for either alcohol or drugs please describe:

_____
_____
_____
_____
_____
_____

What are your plans/goals for the future? _____
_____
_____
_____
_____

Submitting the fee waiver form at the end of this packet to Financial Aid may reduce your cost for this service if you are eligible for financial aid.
Are you planning to submit this form? ___yes ___no

Student ID #: _____

Signature_____ Date_____

Note that any information provided here is strictly confidential

(to be completed at CTC when turning in packet)

University of Idaho

Counseling & Testing Center

Mary E. Forney Hall, Room 306
875 Perimeter Drive MS 3140
Moscow, ID 83844-3140

Phone: 208-885-6716
Fax: 208-885-4354
E-mail: ctc@uidaho.edu
www.uidaho.edu/ctc

Authorization to Release/Obtain/Exchange Confidential Information

I, _____ _____ _____
Print Name Student ID# Date of Birth

AUTHORIZE The University of Idaho Counseling & Testing Center to (initial one only):

_____ **EXCHANGE WITH** _____ **RELEASE TO** _____ **OBTAIN FROM**

_____ UI Student Support Services

_____ UI Disability Support Services

The information to be disclosed is:

_____ All information **OR - check below the information to be disclosed:**

_____ Psychiatric Records

_____ Counseling Records

XX Psychoeducational Assessment

_____ Attendance at Sessions

_____ Other (specify) _____

The purpose of this requested use or disclosure is: ____ Coordination of Care **XX** Academic Issues

_____ Other (specify) _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this type of information will be disclosed if I place my **INITIALS** in the applicable space next to the type of information.

_____ Mental Health Information (including Counseling Records and Psychiatric Records)

_____ Drug/alcohol diagnosis, treatment, or referral information

_____ HIV / AIDS information and STD test results, diagnosis or treatment

This Authorization will expire one year after its effective date or on the date of expiration specified: _____

- I understand that I may revoke this authorization at any time with a written statement to the CTC except to the extent that action has been taken in reliance upon it.
- I understand I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive services at the CTC. I understand I am in no way obligated to sign this consent.

I have read this authorization and I understand it.

_____ _____
Client Signature Printed Name

_____ _____ _____
Date Current Telephone Number Email Address

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Wender Utah Rating Scale (WURS)

Name: _____ Date: _____

Think back to when you were a child (0-12 years old) and indicate how much you were (or had) the following:	Not at all or very slightly (0)	Mildly (1)	Moderately (2)	Quite a bit (3)	Very much (4)
1. Concentration problems, easily distracted					
2. Nervous, fidgety					
3. Inattentive, daydreaming					
4. Hot- or short-tempered, low boiling point					
5. Shy, sensitive					
6. Temper outbursts, tantrums					
7. Trouble with stick-to-it-tiveness, not following through, failing to finish things started					
8. Stubborn, strong-willed					
9. Sad or blue, depressed, unhappy					
10. Disobedient with parents, rebellious, sassy					
11. Low opinion of myself					
12. Irritable					
13. Moody, ups and downs					
14. Angry					
15. Acting without thinking, impulsive					
16. Tendency to be immature					
17. Guilty feelings, regretful					
18. Losing control of myself					
19. Tendency to be or act irrational					
20. Unpopular with other children, didn't keep friends for long, didn't get along with other children					
21. Trouble seeing things from someone else's point of view					
22. Trouble with authorities, trouble with school, visits to principal's office					
23. Overall a poor student, slow learner					
24. Trouble with mathematics of numbers					
25. Not achieving up to potential					

From Ward, Wender & Reimherer (1993) American Journal of Psychology Total _____

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Parents' Rating Scale

Please contact one of your parents (preferably your mother) to answer the following questions about you.

Student's name_____ ID#_____ Date_____

Name of person responding to questions:_____

Instructions: Listed below are items concerning children's behavior and the problems they sometimes have. Read each item carefully and decide how much you think you were bothered by these problems when your child was between six and ten years old. Rate the amount of the problem by putting a check in the column that describes your child at that time.

	Not at all (0)	Just a little (1)	Pretty Much (2)	Very Much (3)
1. Restless (overactive)				
2. Excitable, impulsive				
3. Disturbs other children				
4. Fails to finish things started (short attention span)				
5. Fidgets				
6. Inattentive, distractible				
7. Demands must be met immediately; gets frustrated				
8. Cries				
9. Mood changes quickly				
10. Temper outbursts (explosive and unpredictable behavior)				

From the Am J Psychiatry 150:6, June 1993

Total _____

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University of Idaho

SLIDING FEE SCHEDULE FOR ASSESSMENT SERVICES

COUNSELING & TESTING CENTER

Counseling & Testing Center
Mary E. Forney Hall, Room 306
875 Perimeter Drive MS 3140
Moscow, ID 83844-3140
Phone: 208-885-6716
Fax: 208-885-4354
E-mail: ctc@uidaho.edu
www.uidaho.edu/ctc

The sliding fee schedule for assessment services at the University of Idaho Counseling & Testing Center is based on the students need analysis report used to develop the student's financial aid package. The student must have Student Financial Aid complete the bottom portion of this form before any waiver may be implemented.

Students may fall into one of two categories, Dependent or Self-Supporting. This determination should be indicated on the need analysis report. The fee schedule of Dependent students is based on the parental contribution while that for Self-Supporting students is based on the student's expected contribution. Fees for assessment services will be determined based on the following schedule:

Dependent (parental contribution)	Self-Supporting (student contribution)	Assessment Fee to be charged
$2801 or more	$3701 or more	$350
$2800-2401	$3700-3101	$300
$2400-1701	$3100-2401	$250
$1700-1201	$2400-1601	$200
$1200-801	$1600-1101	$150
$800-501	$1100-701	$100
$500-301	$700-401	$75
$300-0	$400-0	$50

NOTE: This applies to full-time students only. No waiver is available to part-time students. Minimum fees may apply.

AUTHORIZATION TO RELEASE INFORMATION

I _____ hereby attest that I am currently registered for 8 or more credits and
(print your name here)
request that Student Financial Aid provide the indicated information to the Counseling & Testing Center.

_____ _____ _____
(Student Signature) (Student ID Number) (Date)

To be completed by financial aid officer

Student Category (please circle one): _____ Dependent _____ Self-Supporting

Expected Student or Parent Contribution for the year: $_____

_____
(Printed Name of Financial Aid Officer)

_____ _____
(Signature of Financial Aid Officer) (Date)

Please mail or FAX this form to the Counseling & Testing Center, campus zip code 3140, FAX 5-4354

Note that any information provided here is strictly confidential