Attention-deficit/hyperactivity disorder (ADHD) and learning disorders (LD) are complex disorders that require labor-intensive assessment procedures. Because of the extensive time commitment required for these assessments, they are primarily provided as part of training programs for advanced students in the Counseling & Testing Center's (CTC) clinical or counseling psychology doctoral programs. Student trainees perform the assessments under the supervision of a licensed psychologist with expertise in psychological assessment. While this allows the CTC to conduct a higher number of assessments than would be possible otherwise, it also means each assessment is likely to take longer to complete.

Students struggle with academic success for a variety of reasons, and sometimes assessments reveal students do not have ADHD or an LD. However, feedback from the comprehensive assessment will often provide information to improve function or compensate for weaknesses even when a diagnosis is not appropriate. Results may also help the student understand other concerns, such as substance use, anxiety, depression and personality issues.

**Assessment Process**

- The first step is to complete this Pre-Assessment History Packet with as much information as you are able to provide and return it to the University of Idaho Counselling & Testing Center, Mary Forney Hall-Room 306. At that time your name will be placed on a waiting list for the next available time for assessment. All information you provide is strictly confidential.

- When an opening is available, you will be contacted by email.
  - Please make sure that the email you provide us is one that you check regularly. Because of the high demand for these services, we typically send the email to more people than we have spots for and those who respond first will get the appointment.

- There will be an initial appointment of 1-2 hours to gather more in-depth information in order to determine the best course of action. You should bring copies of school records, report cards, previous assessment results or anything else related to your academic history to this initial consultation if at all possible.

- If it is determined a comprehensive assessment is needed, you will need to be prepared to invest 8-10 hours of your time to the process, including most of the day on a designated Saturday.

- There is a fee of $350 if you decide to proceed with the assessment; however, this fee may be reduced to as little as $50 based on need as determined by the Financial Aid Office. If you would like to participate in this sliding fee you will need to complete the Sliding Fee Scale page in the packet. If you feel that your financial situation is significantly different than what the Financial Aid Office has on file (based on the FAFSA), and do not feel you can afford the assessed fee, please ask to speak to the Director of Testing and Assessment.

- The fee for assessment services will be charged to your student account once you actually begin testing.

- While assessment is typically completed within 3-4 weeks of your initial appointment, because this is a training site all scoring, interpretation and writing must be thoroughly reviewed and edited by both the assessment clinician and the Director of Testing and Assessment. Therefore it is typically 4-6 weeks after the completion of all assessment that results are available. At that time you will be provided with in-depth feedback about the results and recommendations as well as a copy of the report itself.

- If you have questions please contact Dr. Steve Saladin, Ph.D., by email at ssaladin@uidaho.edu or by phone at (208) 885-6716
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 CDAR – 885-6307 or 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            ___ Depression/Anxiety

Note that any information provided here is strictly confidential

Rev. 8/23/18
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 prior to college and what years/grades you attended:
____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
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 psychological or emotional difficulties you know of:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
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. If you have ever lost consciousness from a head injury or fever please provide details?


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

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Condition for which it is taken</th>
<th>When Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 currently use marijuana products?  ____ Yes  ____ No
If yes, please describe how you ingest it (smoking, edibles, etc.) and how frequently you use it
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Have you used or do you currently use other 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 do you hope to gain/learn from this assessment? ________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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 or V #: ___________________________

Signature_____________________________________ Date__________________________
The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?
How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing/falling asleep = 0
- Slight chance of dozing/falling asleep = 1
- Moderate chance of dozing/falling asleep = 2
- High chance of dozing/falling asleep = 3

Circle the number corresponding to your choice in the right hand column. Total your score below.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing/falling asleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Watching TV</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g., a theater or a meeting)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

**Total Score = ________________**

### 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:

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


**Total ________**

Note that any information provided here is strictly confidential  

Rev. 8/23/18
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.

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

From the Am J Psychiatry 150:6, June 1993

Note that any information provided here is strictly confidential

Rev. 8/23/18
Authorization to Release/Obtain/Exchange Confidential Information

I, ___________________________________  ____________________  __________________
Print Name          Student ID/V#        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 Center for Disability Access and Resources

The information to be disclosed is:

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

  _____ Psychiatric Records
  _____ Counseling Records
  ____ Psychoeducational Assessment
  _____ Attendance at Sessions
  _____ Other (specify) _____________________________________________

The purpose of this requested use or disclosure is:

_____ Coordination of Care  ____ 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

Note that any information provided here is strictly confidential  Rev. 8/23/18
The sliding fee schedule for assessment services at the University of Idaho Counseling & Testing Center is based on the student's 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:

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

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/V 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  Rev. 8/23/18