Assessment Application
Washington State University Psychology Clinic

Today's Date_____ Client ID #_____

Client Name: _____
(First, Middle, Last)

Address: _____ Phones: Cell: _____

City: _____ State: _____ Zip: _____ Work: _____

Occupation: _____ Message: _____

Birth date: _____ Age: _____ Gender: _____

If we need to contact you, where would you prefer we leave a message? ____ Cell ____Work ____Message

Name of Individual with whom we can leave a message: _____

Have you ever been a uniformed member of any branch of the US Military (Active Duty, Guard or Reserve)?
____Yes ____No Are you a family member (Spouse, Parent, Child) of a Veteran? ____Yes ____No

How did you hear about the Psychology Clinic? _____

Were you referred? _____ If so, by whom? _____

Type of Assessment You Are Seeking:
_____Learning Disability _____Attention Deficit Disorder _____Neuropsychological _____Psychological

Other (please describe): _____

Race/Ethnicity:
____African American/Black/African
____American Indian or Alaskan Native
____Asian American/Asian
____East Indian
____Hispanic/Latino/Latina
____Other (Please specify)_____
____ Arab American/Arab/Persian
____ Native Hawaiian or Pacific Islander
____ Caucasian/White/European American
____ Multi-Racial

What is your country of origin? _____

Relationship Status:
____Single ____Separated ____Civil Union, domestic partnership or equivalent
____Married ____Widowed ____ Engaged
____Divorced

STUDENT INFORMATION
Name of School: _____ Student ID#_____
Current GPA: _____ High school GPA: _____
SAT Verbal Score: _____ SAT Math Score: _____

In grade school and high school, which classes did you like? _____

Have you ever been placed in special education classes? _____YES _____NO

If yes, please describe: _____

Were you ever held back a grade? _____YES _____NO

If yes, which one? _____

List the subjects in which you are having difficulty: _____

_____

Please describe your current difficulties: _____

_____

Do you experience any difficulties understanding spoken or written language? _____YES _____NO

If yes, please describe: _____

_____

Have you ever experienced a head injury, loss of consciousness, or seizures? _____ YES _____ NO

If yes, please describe: _____

_____

Did you experience any complications at birth (e.g., cord around neck)? _____ YES _____ NO

If yes, please describe: _____

Did you reach developmental milestones within normal limits (e.g., learning to walk, talk)? ____ YES ____ NO

If no, please describe: _____

_____

Have you ever been tested for intelligence or achievement in the past? _____ YES _____ NO

If yes, what type of testing? _____

Describe your current sources of stress: _____

_____

Do you have a chronic medical condition/illness (e.g., Diabetes, hypertension)? _____YES _____ NO

If yes, please describe: _____

_____

Are you taking any medications at this time? _____YES _____NO

If yes, please list (include over-the-counter medications): _____

_____

Have you ever abused alcohol or illicit drugs? _____YES _____NO

Are you currently abusing alcohol or illicit drugs? _____ YES _____ NO

Do you have difficulty remembering things? _____YES _____NO
If yes, please describe: _____

_____

Do you have difficulty hearing, or have poor vision and wear glasses? _____ YES _____ NO

If yes, please describe: _____

Is there a deadline by which this testing needs to be completed? _____ YES _____ NO

If yes, by when? _____

Please place check marks by all of the times you or your child/ward are available to attend therapy sessions:

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 am					
1:00 pm					
2:00 pm					
3:00 pm					Closed
4:00 pm					Closed
5:00 pm			Closed		Closed
6:00 pm	Closed		Closed		Closed

Print Client's Name	Client's date of birth
Client Signature (If age 13 or older)	Date

If client is under the age of 18, please also complete the following:

Print Parent/Guardian/Authorized Adult's Name	Relation to Client
Parent/Guardian/Authorized Adult Signature	Date