



Ochester Psychological Services, LLC

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### INITIAL ASSESSMENT FORM

#### CLIENT INFORMATION

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Home Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ : School Grade/Degree: \_\_\_\_\_

Marital Status:  Single  Partnered  Married  Separated  Divorced  Widowed

What is the best way to leave you a confidential message? \_\_\_\_\_

Who referred you to us or how did you hear about us? \_\_\_\_\_

#### RESPONSIBLE PARTY and/or EMERGENCY CONTACT INFORMATION

*If the client is a child or dependent, the custodial parent or legal guardian should be listed here. If the client is an independent adult, only an emergency contact person and phone number must be listed.*

Responsible Party/Contact: \_\_\_\_\_ Home/Cell Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status:  Single  Partnered  Married  Separated  Divorced  Widowed

#### FINANCIAL RESPONSIBILITY STATEMENT (see Client Services Agreement)

*Please indicate the method by which you would like us to handle your account (please check one):*

- I will pay in full each visit. I either do not have health insurance or services are not covered by my plan.
- You are a provider in my health insurance network. As such, I will pay the full amount of fees which are not covered by insurance. I hereby authorize 1) payment directly to OPS of the coverage benefits otherwise payable to me and 2) the release of any medical information necessary to process this claim.
- You are not in my health insurance network, but I would like documentation to send to my insurance company so that I can request reimbursement from them. As such, I will pay in full each visit and you will provide me with a superbill authorizing payment of benefits directly to me. I authorize the release of any medical information necessary to process my claims.

YOUR SIGNATURE BELOW INDICATES THAT THE CLIENT SERVICES AGREEMENT AND HIPAA PRIVACY NOTICE HAVE BEEN MADE AVAILABLE TO YOU & YOU HAVE READ AND UNDERSTAND THEM AND AGREE TO THE TERMS.

\_\_\_\_\_  
(Signature of Client or Responsible Party)

\_\_\_\_\_  
(Date)

**CURRENT CONCERNS**

Please give a brief summary of the concerns that brought you here including current stressors: \_\_\_\_\_

What are your goals in being here? \_\_\_\_\_

What have you tried in the past to address your concerns? \_\_\_\_\_

**HEALTH HISTORY**

**Mental health services and medications** (dates of service, # of meetings, medications, types of treatment).

**Current:** \_\_\_\_\_

**Past:** \_\_\_\_\_

Current or past **thoughts of harming self or others?**  Yes  No

Current family physician (name, address & phone): \_\_\_\_\_

**Current medical problems** (including allergies) and **medications** used including dosage and frequency:

\_\_\_\_\_

**Past medical problems** and use of medications: \_\_\_\_\_

Any serious **accidents or injuries?** (describe and give date or age): \_\_\_\_\_

Any **vision or hearing** problems (including use of glasses/contacts, hearing aids)?  Yes  No

If yes, please explain: \_\_\_\_\_ Dates of last vision and hearing evaluations: \_\_\_\_\_

Any past or present problems with **sleep?** \_\_\_\_\_

Any past or present problems with **weight, appetite or eating?** \_\_\_\_\_

Current height and weight: \_\_\_\_\_ Recent changes in weight or appetite?  Yes  No

**EMPLOYMENT HISTORY**

*Summarize jobs starting from the most current:*

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_ Employer: \_\_\_\_\_ Why left: \_\_\_\_\_

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Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_ Employer: \_\_\_\_\_ Why left: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_ Employer: \_\_\_\_\_ Why left: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_ Employer: \_\_\_\_\_ Why left: \_\_\_\_\_

Any work-related problems?  Yes  No If yes, please describe: \_\_\_\_\_

Ever been fired?  Yes  No If yes, please describe: \_\_\_\_\_

Ever received disciplinary action?  Yes  No If yes, please describe: \_\_\_\_\_

What would client's employers or supervisors have said about him/her? \_\_\_\_\_

Please describe client's military history: \_\_\_\_\_

**LEGAL HISTORY**

Any legal problems or run-ins with the law?  Yes  No If yes, please describe (including dates):

How many traffic tickets has client received? \_\_\_\_ How many car accidents while client was driving? \_\_\_\_

Currently involved in or thinking about being involved in litigation (legal case)?  Yes  No

If yes, please describe: \_\_\_\_\_

**SEXUAL HISTORY**

Sexual orientation: Heterosexual/Straight Lesbian Gay Bisexual Transgendered Questioning

History of sexual abuse, molestation, or rape (if yes, please summarize including ages/dates)? \_\_\_\_\_

Any history of sexually transmitted disease?  Yes  No History of abortion?  Yes  No

Current sexual concerns?\_\_\_\_\_ Use of contraceptives/birth control? \_\_\_\_\_

**ALCOHOL AND DRUG HISTORY**

Substance	Age at First Use	Date of Last Use	Current Use (indicate avg. amount per day, wk, mo, or yr.)	Problems Resulting From Use (i.e. legal, health, work, academic, relationships)
Alcohol	Age	Date	Current Use	Problems
Nicotine (cigarettes, cigars, pipe, chew)	Age	Date	Current Use	Problems
Marijuana/hash	Age	Date	Current Use	Problems
Prescription drugs (recreational use)	Age	Date	Current Use	Problems
Inhalants	Age	Date	Current Use	Problems
Cocaine or crack	Age	Date	Current Use	Problems
Amphetamines, crank, ice	Age	Date	Current Use	Problems
Steroids	Age	Date	Current Use	Problems
Opiates (heroin, codeine, morphine, pain killers)	Age	Date	Current Use	Problems
Barbiturates	Age	Date	Current Use	Problems
Hallucinogens (LSD, mesc, shrooms, ecstasy)	Age	Date	Current Use	Problems
PCP	Age	Date	Current Use	Problems

Ever experienced withdrawal symptoms from alcohol or drugs?  Yes  No

Ever been told had a problem with drugs or alcohol?  Yes  No

Ever felt guilty about drug or alcohol use?  Yes  No

Ever annoyed when someone talked about your drug or alcohol use?  Yes  No

Ever had treatment for drug/alcohol use?  Yes  No

Ever used drugs or alcohol first thing in the morning?  Yes  No

Caffeine use per day (coffee, tea, sodas, chocolate) \_\_\_\_\_

**FAMILY HISTORY**

Who lives in the **current household** and what is the relationship to each?

\_\_\_\_\_

Current **marital or relational satisfaction** (of client if adult, of parent(s) if child) \_\_\_\_\_

Significant **family events** (include marriages, separations, divorces, deaths, trauma, losses, abuse, etc.)

\_\_\_\_\_

Client's **children** (ages, quality of relationship to client, any psychiatric or medical difficulties)

\_\_\_\_\_

**Biological Mother's History:**

Age \_\_\_\_\_ Occupation \_\_\_\_\_ Highest grade completed \_\_\_\_\_

Learning problems:  Yes  No Behavior problems:  Yes  No

Has mother or any of mother's blood relatives ever had any **mental health problems** including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric treatment or hospitalizations? (specify)

\_\_\_\_\_

**Biological Father's History:**

Age \_\_\_\_\_ Occupation \_\_\_\_\_ Highest grade completed \_\_\_\_\_

Learning problems  Yes  No Behavior problems  Yes  No

Have any of father's blood relatives ever had any **mental health problems**? (specify)

\_\_\_\_\_

**Client's Siblings** (names, ages, quality of relationship to client, any psychiatric or medical difficulties):

\_\_\_\_\_

**OTHER**

Cultural/ethnic background: \_\_\_\_\_ Languages spoken in home: \_\_\_\_\_

Religious background or affiliation: \_\_\_\_\_

Relationships with friends (make friends easily, have a best friend, etc.): \_\_\_\_\_

\_\_\_\_\_

Weaknesses/problem areas: \_\_\_\_\_

Strengths/skills, hobbies, interests: \_\_\_\_\_

*The following questions are optional for adults who are not concerned about learning difficulties. For individuals under age 18 and for any adults who may be concerned about ADHD or learning difficulties, please complete the following questions.*

**DEVELOPMENTAL HISTORY**

*If adopted or otherwise limited access to early history, please answer questions to the best of your knowledge.*

Did birth mother use substances (such as cigarettes, alcohol, illegal drugs) or medications during pregnancy?

Yes  No      If yes, please describe: \_\_\_\_\_

**Complications during pregnancy or birth?** (Check all that apply):  bleeding  excess vomiting

infections  x-rays  high blood pressure  accidents or injuries  illnesses  extreme stress

premature birth  caesarean section  breech birth  use of forceps or vacuum  jaundice

breathing problems  anoxia (blue baby)  cord wrapped around neck  feeding problems  birth defects,

other: \_\_\_\_\_

**Developmental Milestones:** Were there any skills learned later than expected such as toilet training, walking, talking, learning to read, tell time, tying shoes etc.? If so, please describe:

**CLIENT SCHOOL HISTORY**

Preschool?  Yes  No

School (name, city, state)	Highest Grades Completed	Grades or GPA	Major, Degree or Certificate
Elementary or Primary:	Grade:		NA
Junior High:	Grade:		NA
High School:	Grade:		
College or University:	Grade:		
Post-graduate:	NA		

Ever skipped a grade or been held back?  Yes  No      If yes, describe \_\_\_\_\_

Ever diagnosed with learning disability?  Yes  No      If yes, describe \_\_\_\_\_

Ever been evaluated for an IEP?       Yes  No      Ever receive special education?       Yes  No

Any behavior problems in school?       Yes  No      If yes, describe \_\_\_\_\_

Ever been  expelled or  suspended?

Learning strengths/skills, favorite subjects/classes: \_\_\_\_\_

Least favorite subjects/classes \_\_\_\_\_

What have teachers said about client? \_\_\_\_\_

## **LEARNING DIFFICULTIES CHECKLIST**

*Please rate yourself or the client on scale of 0 to 4 for each of the symptoms listed below.*

<b>0</b> <b>Never</b>	<b>1</b> <b>Rarely</b>	<b>2</b> <b>Occasionally</b>	<b>3</b> <b>Often</b>	<b>4</b> <b>Very Often</b>	<b>NA</b> <b>Not Applicable/Unknown</b>
<b>Reading</b>					<b>Rating</b>
Poor reader for age.					
Dislikes reading.					
Makes too many mistakes when reading (like skipping words or lines or reading same line twice).					
Difficulty remembering what is read.					
Reverses letters when reading (such as b/d, p/q).					
Switches letters in words when reading (such as god and dog).					
Eyes hurt or water when reading.					
Words tend to blur when reading.					
Words tend to move around the page when reading.					
When reading, has difficulty understanding the main idea or identifying important details.					
<b>Writing</b>					<b>Rating</b>
Messy handwriting for age.					
Dislikes writing.					
Prefers to print rather than writing in cursive.					
Uses an awkward pencil grip.					
Letters run into each other or there is no space between words.					
Difficulty staying within lines.					
Problems with grammar or punctuation.					
Poor speller.					
Difficulty copying off board or from page in book.					
Trouble getting thoughts from brain to paper.					
Can tell a story but cannot write it.					
<b>Motor Skills / Spatial Relationships</b>					<b>Rating</b>
Trouble knowing left from right.					
Difficulty keeping things within columns or coloring within lines.					
Clumsy or uncoordinated.					
Difficulty with hand-eye coordination.					
Difficulty with directional concepts.					
Bumps into things when walking.					
<b>Oral Expressive language</b>					<b>Rating</b>
Difficulty expressing self in words.					
Trouble finding the right word to say in conversations.					
Talks around a subject or trouble getting to the point in conversations.					
Has poor enunciation / unclear speech.					
Mispronounces or uses the wrong word when speaking.					
<b>Receptive Language</b>					<b>Rating</b>
Trouble keeping up or understanding what is being said in conversations.					
Misunderstands people and gives the wrong answers in conversations.					
Difficulty understanding verbal directions.					
Trouble telling the direction sound is coming from.					
Problems filtering out background noises.					
<b>Math</b>					<b>Rating</b>
Poor at basic math skills (adding, subtracting, multiplying and dividing)					
Makes "careless mistakes" in math.					
Switches numbers around.					
Difficulty with word problems.					

<b>Sequencing</b>	<b>Rating</b>
Problems getting words or sounds/syllables in the right order when speaking.	
Difficulty telling time.	
Trouble using the alphabet in order.	
Trouble saying the months of the year in order.	
<b>Abstraction</b>	<b>Rating</b>
Trouble understanding jokes.	
Takes things too literally.	
<b>Organization</b>	<b>Rating</b>
Messy or disorganized.	
Shoves everything into backpack, desk, or closet.	
Multiple piles around room or workspace.	
Difficulty planning time.	
Frequently late or in a hurry.	
Often forget assignments or tasks.	
<b>Memory</b>	<b>Rating</b>
Poor memory.	
Difficulty remembering things from past.	
Trouble remembering recent events.	
Difficulty memorizing things for school/work.	
Knows something one day but not the next.	
Forgets what to say in the middle of saying it.	
Trouble following complex directions.	
<b>Social Skills</b>	<b>Rating</b>
Has a best friend.	
Has few or no friends.	
Has trouble reading body language or facial expressions of others.	
Feelings are often or easily hurt.	
Tends to get into trouble with friends, teachers, parents, or bosses.	
Feels uncomfortable around strangers.	
Teased by others.	
Friends do not call and ask to do things with them.	
Does not get together with others outside of school or work.	
<b>Attention &amp; Activity Level</b>	<b>Rating</b>
Often fidgets or squirms.	
Difficulty remaining seated.	
Easily distracted.	
Difficulty awaiting turn.	
Blurts out answers before question is complete.	
Difficulty following through.	
Difficulty sustaining attention to tasks.	
Shifts from one uncompleted activity to another.	
Difficulty playing or socializing quietly.	
Talks excessively.	
Interrupts or intrudes on others.	
Doesn't seem to listen.	
Loses things.	
Engages in physically dangerous activities without considering consequences.	