FLORIDA STATE UNIVERSITY
ADULT LEARNING EVALUATION CENTER

OFFICE USE ONLY

*Date received:*_____
*Intake Date:*_____
*Client ID:*_____
*Payment Type:*_____

APPLICATION FOR SERVICES

Are you interested in…

__ Evaluation __ ADHD Coaching __ Not Sure

Name			
Date of Birth		Ethnicity	
Age		Gender	
Local Address			
Permanent Address			
Contact Information	Cell Phone: _____ ok to leave message? Yes___ No___ Email address: _____ ok to email? Yes___ No___ Work Phone: _____ ok to leave message? Yes___ No___ Other Phone: _____ ok to leave message? Yes___ No___ Best contact method? *phone message* ___ *e-mail* ___ *text/SMS* ___ *cell carrier*: (e.g., AT&T) _____		
What is your primary language?			
Are you fluent in a language other than English? If yes, which language(s)			___yes ___no
University/College attending			
Date Enrolled			
Major/Program			Estimated College GPA:
Year	___freshman ___sophomore ___junior ___senior ___grad student		
Employer		Job Title	

Who referred you to the Adult Testing Center? How did you learn about our office?

_____ FSU Health Services/your physician *Provider Name*: _____
_____ Counselor/Therapist: *Name/Agency*: _____
_____ Academic Advisor: *Name and Department*: _____
_____ FSU SDRC (Student Disabilities Resource Center)/college disability services center
_____ FSU CARE (Center for Academic Retention and Enhancement)
_____ FSU Student Athlete Academic Services (SAAS)
_____ VA Center
_____ Parent
_____ Friend
_____ Website
_____ Flier/Poster
_____ Orientation Ad
_____ Other: _____

2207 Stone Building · Florida State University · Tallahassee, FL 32306-4464
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Please describe the kinds of problems you are encountering. Please be as specific as possible.

What are your strengths? (e.g., academic strengths, coping strategies)

What kind of services have you already tried? (check all that apply)

- ☐ academic accommodations
- ☐ medication
- ☐ counseling/therapy
- ☐ ADHD coaching
- ☐ tutoring
- ☐ psychological/psychoeducational testing

What kind of help do you hope to receive? (check all that apply)

- ☐ academic accommodations
- ☐ medication
- ☐ counseling/therapy
- ☐ course substitution/waiver
- ☐ ADHD coaching
- ☐ tutoring
- ☐ psychological/psychoeducational testing

COLLEGE HISTORY		
Previous Colleges attended	1. 2. 3.	Date_____ Date_____ Date_____
Previous college degrees or certificates	1. 2. 3. 4.	
Were you required to remediate any subject(s) prior to taking college level courses? YES/NO If Yes, what subject(s)? _____ English _____ Math _____ Reading		
What college courses are most difficult for you at this time? (e.g., algebra, chemistry, Spanish)		

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List college courses you have failed or withdrawn from:
Describe any kind of academic help you have had in college:
Testing History: (circle all that apply) SAT Took previously / Plan to take GRE Took previously / Plan to take ACT Took previously / Plan to take GMAT Took previously / Plan to take PERT Took previously / Plan to take MCAT Took previously / Plan to take LSAT Took previously / Plan to take Other: _____ Took previously / Plan to take

K-12 HISTORY			
Name of high school		Location of high school	
Date Graduated		High School GPA:	
Is this a Weighted GPA? YES or NO		Is it on a 4.0 scale or 5.0 scale? 4.0 OR 5.0	
How many different schools did you attend from K- 12th grade?			
Have you ever repeated a grade?			___yes ___no
If yes, which grades?			
Did you fail any classes in high school?			___yes ___no
If yes, which courses?			
Have you ever been diagnosed as learning disabled?			___yes ___no
If Yes, in what subject (i.e. reading, writing, or mathematics)?			
Have you ever been placed in a special education classroom?			___yes ___no
Did you ever have (please circle): an IEP a 504 plan If you have had an IEP or 504 plan, do you still have this documentation? YES / NO			
Describe any other academic help (e.g. tutoring) you have had in :			
High School			
Middle School			
Elementary School			

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Symptom Checklist

Review of Symptoms:
Please mark X's to indicate which of the following is currently, OR has been a problem:

Symptom	In general	When studying, taking tests, or thinking about academics
Nausea or stomachaches	___	___
Difficulty following instructions	___	___
Depressed mood	___	___
Easily distracted	___	___
Restless	___	___
Careless	___	___
Feeling of losing control	___	___
Poor concentration	___	___
Anxious or worried	___	___
Cannot sit still, fidgets	___	___
Feeling hopeless	___	___
Poor organizational skills	___	___
Palpitations, increased heart rate	___	___
Act as if "driven by a motor"/have non-stop energy	___	___
Irritable	___	___
Trembling or shaking	___	___
Forgetful	___	___
Difficulty sleeping	___	___
Act without thinking, impulsive	___	___
Fails to finish tasks	___	___
Talks excessively	___	___
Shortness of breath, dizziness	___	___
Feel sluggish, low energy, or fatigued	___	___
Difficulty sustaining attention	___	___

PSYCHIATRIC HISTORY	
Have you ever had a psychological evaluation?	___ yes ___ no
If yes, do you still have documentation?	___ yes ___ no
If yes, **NAME** of evaluator:	
Have you ever been diagnosed with ADHD?	___ yes ___ no
If yes, when and by whom?	
Have you ever taken ADHD medication, prescribed or unprescribed?	___ yes ___ no
If yes, which medication?	
Do you take any other psychiatric medication?	___ yes ___ no
If yes, which medication?	
If yes, who prescribed medication?	

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Have you ever been diagnosed with another mental health diagnosis (e.g., anxiety, depression, PTSD, eating disorder, obsessive compulsive)	___ yes ___ no
If yes, which diagnosis? When and by whom?	
Are you currently attending therapy/counseling?	___ yes ___ no
If yes, name of therapist/counselor:	
Have you ever been hospitalized due to a psychological concern?	___ yes ___ no
If yes, please describe:	

Medical History: Describe any serious accidents, illnesses, chronic conditions, or injuries you have had, with approximate age ranges. Describe any consequences (e.g., social, physical, emotional, academic, or behavioral) of the injury/condition.

Hearing/Vision: Do you suspect any problems with your hearing or vision? (includes glasses/contacts) If yes, please describe.

Please sign the following statement:

I, _____, understand that I **will be called to make an intake appointmen**t at the Adult Learning Evaluation Center. If I schedule an appointment and am unable to appear, I agree to call at least 24 hours in advance for an intake and 48 hours in advance for an evaluation appointment time. I understand that if I do not call in advance to cancel my appointment, I may experience a delay in being rescheduled. I understand that if I cancel or fail to appear three times for an intake appointment, I will not be rescheduled.

_____ _____

Signature *Date*

Do Not Just Type Name if Completed Online
Must Be Physical Signature or a Digtal Signature

For Office Use Only:

__ Evaluators under sup	__ 4 to 8 weeks
__ 3-4 sessions	__ Payment
__ What to expect	__ ROI
__ Comprehensive MH	__ Scheduling limited
__ No Dx guaranteed	__ Cancellation Fee

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