Name: ___________________________ Date: __________________

Phone: ___________________ Student ID: ___________ Date of Birth: _________

Class Level: ___________________________ Major: ______________________

CURRENT EDUCATION & DIFFICULTIES

1. When do you plan to graduate? _____________________________________________

2. What are the reasons for your referral to Disability Services? Please state the problems you experience in your own words.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

3. Describe any difficulties you are currently experiencing in your classes.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

4. What is your best academic area? ____________________________________________

5. What is your weakest academic area? _________________________________________

6. How much time per week do you devote to studying outside of class? ______________

7. What is your current Grade Point Average (GPA)? ________________________________

8. Are you currently on academic probation or disqualification?  
   □ Yes  □ No
PAST EDUCATION

1. In what grade did you start having problems in school, and what problems were there?


2. Have you ever been tested for a learning disability?  □ Yes  □ No

If yes, what was the outcome of this assessment? ____________________________

3. Have you ever been placed in a special education or remedial class?  □ Yes  □ No

If yes, what type of class were you in? ________________________________

4. Did you receive instruction in another language other than English at the...

   Elementary level?  □ Yes  □ No  If yes, how many years? _______

   Secondary level?  □ Yes  □ No  If yes, how many years? _______

5. Do you read or write another language?  □ Yes  □ No

If yes, what language(s)? _______________________________________

STUDY HABITS & LEARNING

1. Check any areas in which you have problems with organization:

   □ Integrating information from many sources

   □ Readying materials (e.g. term papers, class assignments, etc.)

   □ Identifying steps of a task
☐ Being prepared for class (taking papers, pens, having completed readings)
☐ Outlining information

2. Check all the areas in which you experience time management problems:

☐ Starting a task ☐ Staying on task ☐ Completing a task/assignment

☐ Getting to class on time ☐ Keeping appointments

3. Are you easily distracted by:

☐ Noise ☐ Music ☐ Television

☐ Colors ☐ Visuals ☐ Clutter

☐ Movement ☐ Lighting ☐ People talking

4. Do you have problems following multiple directions given in class? ☐ Yes ☐ No

5. Do you have trouble recalling facts and details? ☐ Yes ☐ No

6. Are you easily frustrated when are you:

☐ Learning new tasks ☐ Studying ☐ Taking tests ☐ Meeting new people

7. Are you overly restless: ☐ When studying ☐ Before exams ☐ In class

8. Do you often respond without thinking? ☐ Yes ☐ No

9. Do you experience difficulty with memorization? ☐ Yes ☐ No
1. Do you experience frustration when reading?  □ Yes  □ No

2. Do you like to read?  □ Yes  □ No

3. Are you a slow reader?  □ Yes  □ No

4. Are you comfortable reading aloud?  □ Yes  □ No

5. Do your eyes tire easily when reading?  □ Yes  □ No

6. Do you have problems with:
   □ Understanding what you read?  □ Locating the main idea?
   □ Reading or skimming quickly?  □ Sounding out unfamiliar words?

7. Do you have difficulty understanding the meaning of new words from the context?  □ Yes  □ No

8. Do you use visual cues when reading, such as italicized print, bold face print, punctuation, graphs, maps, and diagrams?  □ Yes  □ No

9. When reading, do you often:
   □ Reverse letters/numbers?  □ Add letters?  □ Confuse similar words?
   □ See letters/numbers out of order?  □ Skip lines?  □ Omit letters?
MATHEMATICS

1. Do you have problems with basic math skills, such as:
   □ Addition? □ Subtraction? □ Multiplication? □ Division?

2. Do you have difficulty sequencing steps of a task in math? □ Yes □ No

3. Do you have difficulty with mathematical concepts, such as:
   □ Word problems? □ Place value? □ Decimals? □ Fractions?
   □ Formulas? □ 3D Figures? □ Geometry? □ Calculus?

WRITING

1. Do you have difficulty expressing your ideas in writing? □ Yes □ No

2. Do you experience problems with handwriting
   □ Illegible writing □ Mixing printing and cursive or capitals with lower case

3. Do you have spelling problems, such as:
   □ Omitting letters? □ Adding letters? □ Substituting letters?
   □ Reversing letters? □ Dividing words into syllables?
   □ Spelling phonetically? □ None of the Above

4. Do you experience problems with the mechanics of writing, such as:
5. Do you use a limited vocabulary when writing?  
☐ Yes  ☐ No

6. Do you have problems with writing tasks, such as:

☐ Forms  ☐ Personal letters  ☐ Term papers  ☐ Notes
☐ Business letters  ☐ Memos  ☐ Résumés  ☐ Job applications
☐ None of the Above

RECEPTIVE AND EXPRESSIVE LANGUAGE

1. Do you have difficulty expressing thoughts and ideas verbally?  
☐ Yes  ☐ No

2. Do you often mispronounce words?  
☐ Yes  ☐ No

3. Do you use the wrong word by mistake or have trouble finding the “right word” to describe something?  
☐ Yes  ☐ No

4. Do you have difficulty retelling information you’ve read, seen, or heard?  
☐ Yes  ☐ No

5. Do you limit your vocabulary when speaking?  
☐ Yes  ☐ No

6. Do you have difficulty understanding or keeping up with lectures?  
☐ Yes  ☐ No

7. Do you have difficulty following verbal directions?  
☐ Yes  ☐ No

8. Do you often feel like you haven’t heard someone well or didn’t “get” what the person said?  
☐ Yes  ☐ No
HISTORY

1. Please check any conditions which apply to you now or in the past:
   - [ ] Head Injury
   - [ ] Diabetes
   - [ ] Seizures
   - [ ] High Fever
   - [ ] Hearing Loss:
   - [ ] Other ____________________________
   - [ ] None of the Above

2. Do you have any difficulty with your vision or hearing? [ ] Yes  [ ] No

3. Have you ever been diagnosed with a speech problem or auditory processing disorder? [ ] Yes  [ ] No

4. Have you experienced frequent anxiety about: [ ] Test taking  [ ] A subject or class

5. Check any of the following additional resources you have used:
   - [ ] Private Counseling Services
   - [ ] Relaxation/Meditation/Biofeedback
   - [ ] Other (please specify) ____________________________________________
   - [ ] None of the Above

SOCIAL LIFE & ACTIVITIES

1. Are you currently employed? [ ] Yes  [ ] No
If yes, what is your position?_________ Hours per week?_________

What activities are you involved in (clubs, student government, etc.)?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

IN YOUR OWN WORDS

Use the remainder of this page to write a brief summary of your academic and career goals.

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Student Signature and Date:_____________________________________________