Georgia State University | REGENTS CENTER FOR LEARNING DISORDERS

Client Case History Questionnaire

The information requested on this questionnaire is required as part of your evaluation. Please feel free to add as much information as you want. Use the backs of pages if necessary.

The highest standards of professional confidentiality are maintained. Information about any particular client can be released only with the explicit written consent of that person except in exceptional legal situations.

Identifying Information

Name: _____ SS#: _____
Last First MI Preferred Last four digits only

Address: _____ Birthdate: _____

_____ Home Phone: _____
City State Zip Code May we leave a voicemail? ☐ yes ☐ no

Cell Phone: _____
May we leave a voicemail? ☐ yes ☐ no

Ethnicity: _____ Marital Status: _____ Gender: _____

Who is filling out this form? _____ Today's Date: _____

Who will be responsible for scheduling testing sessions? _____

Have you ever been diagnosed with a learning disability? ☐ yes ☐ no

Have you ever been diagnosed with Attention Deficit Disorder, either with or without hyperactivity? ☐yes ☐ no

Which? ☐ with hyperactivity ☐without hyperactivity

Date of your last psychological evaluation? _____ Please provide copies of all reports.

By whom? _____

Are there any left handers in your immediate family? _____

Family Background

1. Spouse Information

   Name _____

   Occupation: _____ Office Phone: _____

   Difficulties in learning? ☐ yes ☐ no Describe: _____

   Other disabilities (e.g., physical, psychological)? Describe: _____

2. Do you have children? ☐ yes ☐ no

Names	Ages	Highest Grade Completed	Difficulties in Learning or Other Disabilities (Describe)

3. Father's Information (pertains to your biological father)

   Name: _____ Home Phone: _____

   Address: _____ Work Phone: _____

   _____

   Occupation: _____ Educational Level: _____

   Difficulties in learning? ☐ yes ☐ no Describe: _____

   Other disabilities (e.g., physical, psychological)? Describe: _____

4. Mother's Information (pertains to your biological mother)

   Name: _____ Home Phone: _____

   Address: _____ Work Phone: _____

   _____

   Occupation: _____ Educational Level: _____

Difficulties in learning? ☐ yes ☐ no Describe: _____

Other disabilities (e.g., physical, psychological)? Describe: _____

5. Do you have sisters and brothers? ☐ yes ☐ no (add additional pages if needed)

Names	Ages	Highest Grade Completed	Difficulties in Learning or Other Disabilities (Describe)

6. Other Significant Information About Your Family

Please indicate the existence of any of these conditions in your family. Indicate the relationship of the person to you (e.g., father, maternal grandmother):

Mental Health Disorders ☐ yes ☐ no Who? _____ What? _____

Mental Retardation ☐ yes ☐ no Who? _____ What? _____

Epilepsy ☐ yes ☐ no Who? _____

Other Neurological Disorder ☐ yes ☐ no Who? _____ What? _____

Autism Spectrum Disorder ☐ yes ☐ no Who? _____ What? _____

Serious Chronic Illness ☐ yes ☐ no Who? _____ What? _____

Speech/Language Problems ☐ yes ☐ no Who? _____ What? _____

Substance Abuse ☐ yes ☐ no Who? _____ What? _____

Trouble with the Law ☐ yes ☐ no Who? _____ What? _____

What languages are spoken in your home? _____

What language did you learn first? _____

At what age did you begin to learn English? _____

How often has your family moved? _____

Birth History (pertains to your biological mother)

1. History of miscarriage? _____ Stillbirths? _____

   Please indicate when miscarriages and/or stillbirths occurred in relation to your birth.

   _____

2. Pregnancy with you:

   Bleeding: ☐ yes ☐ no Illness: ☐ yes ☐ no Infections: ☐ yes ☐ no

   Accidents: ☐ yes ☐ no RH Incompatibility: ☐ yes ☐ no

   Length of Pregnancy: Was the delivery ☐ early ☐ on time ☐ late By how much? _____

   Medications Taken? ☐ yes ☐ no What? _____

   Explanation of unusual circumstances? _____

3. Birth of Client

   Labor: False? ☐ yes ☐ no Induced? ☐ yes ☐ no Length? _____

   Anesthesia? ☐ yes ☐ no Natural? ☐ yes ☐ no

   Type of Birth: Normal? ☐ yes ☐ no Dry? ☐ yes ☐ no Breech? ☐ yes ☐ no

   Forceps? ☐ yes ☐ no Caesarean? ☐ yes ☐ no Birthweight? _____

   Complications: _____

   Apgar Score (if known): _____

   Color: Normal? ☐ yes ☐ no Blue? ☐ yes ☐ no Jaundiced? ☐ yes ☐ no

   Transfusions? ☐ yes ☐ no Incubator required? ☐ yes ☐ no How long? _____

   Difficulties sucking, swallowing or feeding? ☐ yes ☐ no Explain. _____

   Explanation of unusual circumstances? _____

   _____

Developmental History

1. At what age did you:

   Say your first word? _____ Sit unassisted? _____

   Understand speech? _____ Walk unassisted: _____

   Use 2-word sentences? _____

   Stop using "baby" talk? _____

2. Did your family, friends, teachers, etc. ever have difficulty understanding your speech? ☐ yes ☐ no

   If so, please explain. _____

3. What skills were hard for you to learn as a preschooler? _____

   _____

   _____

4. Did you tend to get in trouble frequently in school? ☐ yes ☐ no

   What for: _____

5. Were you ever suspended or expelled from school? ☐ yes ☐ no

   What for: _____

Medical History

1. Childhood diseases

Measles?	☐ yes	☐ no	Age _____	Explain: _____
Meningitis?	☐ yes	☐ no	Age _____	Explain: _____
Encephalitis?	☐ yes	☐ no	Age _____	Explain: _____
Whooping Cough?	☐ yes	☐ no	Age _____	Explain: _____
Scarlet Fever?	☐ yes	☐ no	Age _____	Explain: _____
Ear Infections?	☐ yes	☐ no	Age _____	Explain: _____
Chicken Pox?	☐ yes	☐ no	Age _____	Explain: _____

Pneumonia? ☐ yes ☐ no Age _____ Explain: _____

Frequent Colds? ☐ yes ☐ no Age _____ Explain: _____

Allergies? ☐ yes ☐ no Age _____ Explain: _____

Others? ☐ yes ☐ no Age _____ Explain: _____

2. Have you ever received any blows to the head that required treatment in a hospital or emergency room?

☐ yes ☐ no When? _____

Were you unconscious? ☐ yes ☐ no For how long? _____

How did it happen? _____

3. Have you ever had seizures? ☐ yes ☐ no At what age? _____

Did you receive medication? ☐ yes ☐ no Specify: _____

When was your last seizure? _____

Known cause for seizures? _____

4. Have you ever been diagnosed with or treated for stress, anxiety, depression, substance abuse, or other types of psychological problems?

As a child? ☐ yes ☐ no Specify: _____

As an adult? ☐ yes ☐ no Specify: _____

5. Have you ever had injuries or accidents requiring medical treatment? ☐ yes ☐ no

Specify: _____

6. Have you ever been hospitalized? ☐ yes ☐ no When? _____

Length of hospitalization(s)? _____

Purpose? _____

7. Were there any changes in thinking, behavior, or school performance following illnesses, blows to head, seizures, injuries or hospitalizations?

☐ yes ☐ no Specify: _____

Current Medical Condition

1. Describe your present health. _____

2. Are you presently on medication? ☐ yes ☐ no

Current Medications

Type	Amount	Frequency	Duration of Treatment	Reason

3. Have you been on medication in the last five (5) years? ☐ yes ☐ no

Medication History

Type	Amount	Frequency	Duration of Treatment	Reason

4. Are you allergic to any drugs? ☐ yes ☐ no Please specify: _____

5. How is your appetite? _____

Do you have food allergies? ☐ yes ☐ no Please specify: _____

Are you trying to gain or lose weight? ☐ gain ☐ lose ☐ neither

Have you recently had any weight gain or weight loss? ☐ gained ☐ lost ☐ neither

Height: _____ Weight: _____

6. How many hours do you typically sleep each night? _____

Is this adequate for you to function well? ☐ yes ☐ no Do you have difficulty sleeping? ☐ yes ☐ no

7. Do you wear glasses or contact lens? ☐ yes ☐ no Last exam: _____

☐ near-sighted ☐ far-sighted ☐ other

8. Have you used any of the following substances?

Substance	Current Use: *please check which of these you have used in the past 6 months*			**If you have ever** used this substance, at what age did you ***first*** use it?			
	Never	Sometimes	Often	12 or under	13-17	18-22	22 +
Caffeine							
Cigarettes							
Beer							
Wine or wine coolers							
Liquor							
Marijuana							
Cocaine or crack							
Hallucinogens (e.g. LSD)							
Uppers (non prescription)							
Downers (non prescription)							
Heroin or opiates							
Designer Drugs							
Inhalants							
Methamphetamine							

Educational Background

Elementary and Secondary School History

1. Did you attend public or private schools? _____

2. How many schools did you attend? Indicate when moves took place.

_____

_____

_____

3. Did you repeat any grades in school? ☐ yes ☐ no Specify: _____

4. What things were hard for you in elementary school.

_____

_____

5. What things were hard for you in junior high and high school.

_____

_____

_____

6. Did you or will you graduate high school? ☐ yes ☐ no Graduation date? _____

7. Did you earn a GED? ☐ yes ☐ no Graduation date? _____

8. High school grade point average? _____

9. Best S.A.T. scores (if taken): Verbal _____ Math _____ Was test: ☐ Standard Time ☐ Extended Time

10. Best A.C.T. scores (if taken): Was test: ☐ Standard Time ☐ Extended Time

11. In high school, have you taken or are you currently taking?

Algebra?	☐ yes	☐ no	# of semesters _____	letter grade earned _____
English Composition?	☐ yes	☐ no	# of semesters _____	letter grade earned _____
Foreign Language?	☐ yes	☐ no	# of semesters _____	letter grade earned _____

Special Education Services or Tutoring

1. Did you receive any special education services in school? ☐ yes ☐ no Years _____
2. Did you have an IEP or 504 Plan? ☐ yes ☐ no Years _____
3. Did you attend resource classes? ☐ yes ☐ no Years _____
4. Did you attend self-contained classes? ☐ yes ☐ no Years _____
5. Did you attend a school or program for students with special needs? ☐ yes ☐ no Years _____
6. Did you attend any other types of academic support programs? ☐ yes ☐ no Years _____

   Specify type, duration and dates of attendance: _____
7. Describe tutoring you have had (subjects, hours/week): _____

_____

8. What help did you find the most beneficial and why? _____

_____

History of Learning Difficulties

1. What things are currently most difficult for you? _____

_____

_____

2. When was your problem first observed? _____

3. Evaluations related to your learning difficulties (list chronologically).

Date	Examiner	Place of Evaluation	Diagnosis

4. Have you ever had any of the following medical evaluations? Specify diagnosis and give date.

   a. EEG ☐ yes ☐ no Specify: _____

   b. CT/MRI ☐ yes ☐ no Specify: _____

   c. Neurological examination ☐ yes ☐ no Specify: _____

   d. Other ☐ yes ☐ no Specify: _____

College History

1. Colleges and/or Technical Schools Attended (indicate dates): _____

   _____

   _____

2. College Currently Attending _____

3. List Current Courses _____

   _____

   _____

4. Have you taken any Learning Support classes? ☐ yes ☐ no

   If yes, which areas? ☐ Reading ☐ English ☐ Math

   Will you need to take any Learning Support classes? ☐ yes ☐ no

5. Do you need to take the Regent's Exam? ☐ yes ☐ no

6. Are you required to take foreign language courses for your degree? ☐ yes ☐ no ☐ don't know

7. In college, have you taken or are you currently taking?

   Algebra? ☐ yes ☐ no # of semesters _____ letter grade earned _____

   English Composition? ☐ yes ☐ no # of semesters _____ letter grade earned _____

   Foreign Language? ☐ yes ☐ no # of semesters _____ letter grade earned _____

8. What are your best subjects? _____

9. What are your poorest subjects? _____

10. Current Cumulative G.P.A.: _____ Major: _____

11. Class Status: ☐ freshman ☐ sophomore ☐ junior ☐ senior ☐ graduate

12. Anticipated Graduation Date: _____

Work History (list all salaried and volunteer positions beginning with the most recent)

Title	Responsibilities	Dates

1. Have you ever been, or are you currently involved in any legal difficulties? ☐ yes ☐ no

   Specify: _____

   _____

2. Are you a veteran of the armed forces? ☐ yes ☐ no Dates of service: _____

Current Plans

Other individuals may have helped you complete this case history. However, you should complete this section in a frank, complete and thoughtful manner. Please use your own words and handwriting.

1. What is <u>your</u> purpose in seeking this evaluation? _____

   _____

2. Describe how your learning problems affect you now. _____

   _____

   _____

3. What type of special services do you believe you will need in college and why? _____

   _____

   _____

4. Describe your strengths as you see them. _____

   _____

5. What do you enjoy doing in your spare time? _____

Current Plans, continued

6. In what college activities do you currently or plan to participate (e.g., fraternity/sorority, intramural sports, student government, intercollegiate sports)?

_____

7. What are you interested in studying? _____

_____

8. What do you plan to do after college? _____

_____

9. Additional information: _____

_____

_____

I have provided complete, true and accurate information to the best of my knowledge. I I understand that false or inaccurate information may invalidate my evaluation.

Signed: _____ _____
Applicant Date