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? _____

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

By whom? _____

Birth History

1. Maternal 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 receive therapy? ☐ speech ☐ physical ☐ occupational Age: _____ How long? _____

Medical History

1. Have you ever been diagnosed with the following:

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: _____
Many 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 had injuries or accidents requiring medical treatment? ☐ yes ☐ no

Specify: _____

5. Have you ever been medically hospitalized? ☐ yes ☐ no When? _____ How long? _____

Purpose? _____

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

□ yes □ no Specify: _____

7. 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: _____

Medical History- continued:

8. Have you used any of the following substances (do not include those taken as prescribed by a medical professional)

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 (LSD, PCP)							
Designer (Bath Salts, K2)							
Heroin or opiates							
MDMA/Ecstasy							
Inhalants (paint, gasoline)							
Methamphetamine							
OTC (cough syrup, allergy)							

Psychiatric History

1. Have you ever been diagnosed with the following? If so, when and by whom (psychologist, school, medical doctor):

Disorders	**Childhood (before 18)**	**Adult**	**By Whom**
Intellectual Disability			
Autism Spectrum			
Language/Communication			
ADHD			
Learning- Reading			
Learning- Math			
Learning- Writing			
Anxiety			
Depression			
Schizophrenia			
Bipolar Disorder			
Obsessive-Compulsive			
PTSD			
Anorexia/Bulimia			
Substance Use			
Other _____			

Psychiatric History- continued:

2. Have you ever been psychiatrically hospitalized? □ yes □ no When? _____ How long? _____

3. Have you received counseling or therapy? □ yes □ no When? _____ How long? _____

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? _____

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

9. Do you wear glasses or contact lenses? ☐ yes ☐ no Last eye exam: _____

Are you: ☐ near-sighted ☐ far-sighted ☐ other

Family Background

1. Spouse Information

   Name _____

   Occupation: _____ Phone: _____

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: _____

Family Background- continued:

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? _____

Intellectual Disability ☐ 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? _____

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. 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: _____
6. What things were hard for you in elementary school?

   _____

   _____

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

   _____

   _____

8. Did you or will you graduate high school? ☐ yes ☐ no Graduation date? _____
9. Did you earn a GED? ☐ yes ☐ no Graduation date? _____
10. High school grade point average? _____
11. Best S.A.T. scores (if taken): Verbal _____ Math _____ Was test: ☐ Standard Time ☐ Extended Time
12. Best A.C.T. scores (if taken): English_____ Math_____ Reading_____ Science_____ Composite_____

    Was test taken with: ☐ Standard Time ☐ Extended Time

Educational History- continued:

13. 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? ☐ yes ☐ no 504 plan? ☐ yes ☐ no Years _____

   What category? (e.g. learning disability, other health impairment, etc) _____
3. Did you attend self-contained classes? ☐ yes ☐ no Years _____
4. Did you attend a school or program for students with special needs? ☐ yes ☐ no Years _____

   Specify: _____
5. Did you attend any other types of academic support programs? ☐ yes ☐ no Years _____

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

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

   _____

9. Previous evaluations related to your learning difficulties (list chronologically)

Date	Examiner	Place of Evaluation	Diagnosis

College History

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

_____

_____

2. List Current Courses: _____

_____

_____

3. Have you taken any Learning Support classes (course numbers below 100)? ☐ yes ☐ no

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

   Have you passed them? ☐ yes ☐ no

4. 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. Degree Program: ☐ Certificate ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate/Professional

13. Anticipated Graduation Date: _____

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

_____

_____

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 your academic performance 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 understand that false or inaccurate information may invalidate my evaluation.

Signed: _____ _____
Applicant Date