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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 conditions.

Name: Last First MI Preferred

SS#: Last four digits only

Address:

Birthdate:

Home Phone:

City State Zip Code

May we leave a voicemail? yes no

Ethnicity

- Asian
- Black
- Hispanic
- White
- Multiracial
- Other

Marital Status

- Single
- Married
- Widowed
- Divorced

Gender

- Male
- Female

Mobile Phone:

May we leave a voicemail? yes no

Who is filling out this form?

Today's Date (mm/dd/yyyy)

Who will be responsible for scheduling testing?

Date of your last psychological evaluation? (mm/dd/yyyy)

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? 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	Age	How long?
☐ physical	Age	How long?
☐ 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

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

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

Family Background

1. Spouse Information

Name

Occupation: Phone:

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? What?

Other Neurological Disorder ☐ yes ☐ no Who? What?

Autism Spectrum Disorder ☐ yes ☐ no Who? What?

Serious Chronic Illness ☐ yes ☐ no Who? What?

Speech/Language ☐ yes ☐ no Who? What?

Problems 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 SAT. scores (if taken): Verbal Math Was test: ☐ Standard time ☐ Extended time
12. Best ACT. 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 (mm/dd/yyyy)	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 ☑ — Have you passed reading? ☐ yes ■ no
   - English ☑ — Have you passed English? ☐ yes ■ no
   - Math ☑ — Have you passed math? ■ 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 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

01/01/1985
Date (mm/dd/yyyy)