DISABILITY QUESTIONNAIRE

This questionnaire **MUST** be completed by the **STUDENT**.

Name: ______________________________________ Date: _______________________

Phone: ____________________ Red ID #:______________________________________

Date of Birth: _________________ Place of Birth: ______________________________

Class Level: ___________________________ Major: ___________________________

____Undergraduate ____Transfer ____Graduate ____*Non Degree
*enrichment, career advancement, personal interest

Have you previously been tested or diagnosed with a disability?

_____ No
_____ Yes, date(s) of diagnosis/testing ______________________________________
 _____ Diagnosis/testing is enclosed.
 _____ I will have the diagnosis/testing forwarded to you.
 _____ This information is no longer available.

What are the reasons for your referral to SDS? Please state the problems you experience in your own words. ____
____
____

List academic areas which are of greatest concern to you: _________________________
____

1. If you are enrolled at SDSU, list your current classes. Describe any difficulties you are experiencing.

Class	Difficulties
___________________	____
___________________	____
___________________	____
___________________	____
___________________	____

2. What is your current Grade Point Average (GPA)?_________

3. Are you currently on academic probation? ____Yes ____No

4. Have you been disqualified from SDSU? ____Yes ____No

5. Check any of the following tests (competency requirements) that you are having difficulty passing:
   ____ ELM ____ Math Placement/TMA ____ GSP
   ____ EPT ____ WPA (writing proficiency assessment)

6. Have you attempted coursework to fulfill the competency requirements?
   ____Yes ____No
   If yes, how many times: General Math Studies (90, 91, 99) _______
   Rhetoric and Writing Studies (92) _______
   Other: ____________________ _______

7. Check any of the following campus resources you have used:
   ____ Psychological Services
   ____ Math Center
   ____ General Math Studies (90, 91, 99) -- How many times? ___________
   ____ Rhetoric and Writing Studies (92) -- How many times? ___________
   ____ Career Services
   ____ Student Disability Services
   ____ Speech and Hearing Clinic
   ____ Educational Opportunity Program (EOP)
   ____ HCOP

8. Check any of the following additional resources you have used:
   ____ Alcohol/Drug Rehabilitation
   ____ In-patient/Out-patient Psychiatric Care
   ____ Private Counseling/Psychological Services
   ____ Optometric/Ophthalmological Treatments
   ____ Relaxation/Meditation/Biofeedback Training
   ____ Other (specify): ____
   Of those checked, please describe further: ____________________________________
   ____
   ____

Family History:

1. Does anyone in your family have a Learning Disability or any other disability (i.e., physical, emotional, vision or hearing impairment)?
   Father ____Yes ____No ____Don't know
   Mother ____Yes ____No ____Don't know
   Sibling ____Yes ____No ____Don't know
   Children ____Yes ____No ____Don't know
   If yes, describe: ____

2. Were you adopted? ____Yes ____No

3. Describe any family issues which you feel have affected your learning.
____
____

Language History

1. What language(s) is/are spoken in your home? ____________________

2. What language(s) were you first exposed to? ____________________

3. Describe any problems you had in learning your first language. ____________________
____

4. What language(s) did your parents/relatives speak to you prior to entering school?
   Father ____________________
   Mother ____________________
   Other relatives ____________________

5. If English was not your first language, at what age did you begin to learn English? _____

6. Are your parents:
   ___ more fluent in English
   ___ more fluent in a language other than English
   ___ about the same in both

Health History:

1. Were there any medical complications before, during, or after your birth?
   ____Yes ____No

2. Please check any conditions which apply to you now or in the past:

____	Head injury	___	Ear infections	____	Asthma
____	Diabetes	___	Vision problems	____	Allergies
____	Seizures/Epilepsy	___	Hearing Loss	____	High fevers
____	Encephalitis	___	Concussion	____	Stroke
____	Meningitis	___	Near drowning	____	Unconscious

   ____ Other (specify): ____________________

3. Have you ever been hospitalized? ____Yes ____No
   If yes, when, why and for how long? ____________________
____

4. Has illness or injury ever interrupted your attendance in school?
   ____Yes ____No If yes, how long and what grade? ____________________

5. Have you been on any medication in the past? ____Yes ____No
If yes, name of the medication(s): ____
____

6. Are you now on any medication? ____Yes ____No
If yes, name of the medication(s): ____
____

7. Do you use alcohol? ____Yes ____No
If yes, describe how much, and how frequently: ______________________________
____

8. Have you ever used any other substances? ____Yes ____No

9. Are you currently using any other substances? ____Yes ____No

10. Have you had an eye exam in the last two years? ____Yes ____No
Check all that apply:
____Glasses or contacts ____Eye surgery
____Near sighted ____Vision problems worsened
____Astigmatism ____Other

11. Have you had a hearing exam in the last two years? ____Yes ____No
____Do you have a history of ear infections?
____Is it harder to hear people when they turn their back to you?
____Does listening take energy and effort?
____Is it harder to hear with background noise present?

12. Have you ever had a neurological exam? ____Yes ____No

13. Have you ever had difficulties with attention, concentration, or hyperactivity?
____Yes ____ No
If yes, please describe: ____
____

14. Have you ever had emotional problems (e.g. anxiety, depression, etc.)?
____ Yes ____ No

15. Have you ever been hospitalized for emotional problems? ____Yes ____No

16. Have you ever participated in individual or group counseling? ____Yes ____No
If yes, please indicate what type of counseling: ______________________________
____
____

Education History:

1. How many schools did you attend from kindergarten through 12th grade? ______________

2. As far as you can recall, in what grade did you first start having problems in school and what problems were there? ____
____

3. Were you ever tested for eligibility for special education and/or services for the disabled prior to enrollment at SDSU? ____Yes ____No
If yes, when were you tested, by whom and what services were used? ______________
____
____
Can you provide documentation or assessment results? ____ Yes ____ No

4. Have you ever been placed in a special education or remedial class?
____Yes ____No
If yes, what type of class were you in (describe)? ________________________________

5. Do you read or write another language?: ____ Yes ____ No
If yes, what language(s)?: ____

6. Which courses were the most difficult for you in high school: ______________________
____

7. Check any of the following areas that give or have given you trouble:
____ Following oral directions
____ Following written directions
____ Organizing ideas and information
____ Drawing conclusions, making inferences
____ Understanding abstract concepts
____ Finding the "right word" to describe something orally
____ Expressing ideas precisely in writing
____ Writing legibly
____ Reading comprehension
____ Reading rate
____ Sounding out unfamiliar words
____ Mathematical reasoning and word problems
____ Mathematical computation
____ Remembering specific course vocabulary

8. Why do you think you have had problems in school? (check all that apply)
____Specific learning disability
____Physical handicap
____Limited ability
____Emotional problems
____Economic disadvantage
____Tasks too difficult
____Home environment
____Lack of school interest
____Bad luck
____Poor attendance

9. What were your highest SAT scores? __________Verbal __________Math

General Information:

1. Are you right handed? ____ left handed? ____
2. Are you employed? ____Yes ____No
   If yes, where? ____
   How many hours per week? _________ What is your position? __________
   ____
3. Describe your current social relationships: ______________________________
   ____
   ____
4. Check all areas that give you trouble:
   ____ Going to class on time
   ____ Going to class prepared (e.g., taking pens, paper, etc.)
   ____ Becoming motivated to start work
   ____ Budgeting time
   ____ Sticking with an assignment until completion
   ____ Test-taking anxiety
   ____ Lack of self-confidence
   ____ Making new friends
   ____ Understanding humor and sarcasm
   ____ Find yourself fidgeting or feeling restless
   ____ Have difficulty awaiting your turn
   ____ Blurt out answers to questions before they are completed
   ____ Following through on instructions from others
   ____ Have difficulty sustaining attention in tasks
   ____ Excessively shift from one activity to another
   ____ Talk excessively
   ____ Have difficulty being quiet or relaxed
   ____ Interrupt or intrude on others
   ____ Have difficulty listening to others
   ____ Often lose or misplace things
   ____ Often act without considering the consequences

Work and Study Habits:

1. Check any areas in which you have problems:
   ____ Notetaking
   ____ Highlighting
   ____ Essay tests
   ____ Outlining
   ____ Library resources
   ____ Multiple choice tests
   ____ Other: ____

2. Do you have problems following multiple directions given in class?
   ____Yes ____No

3. Where do you usually study? ____

4. Do you have trouble recalling facts and details? ____Yes ____No

5. Are you easily distracted by:
   ____ Noise ____ Music ____ Television
   ____ Colors ____ Visuals ____ Clutter
   ____ Movement ____ Many people talking

6. Are you easily frustrated when:
   ____ Learning new tasks ____ Studying
   ____ Taking tests ____ Meeting new people

7. Do you often respond without thinking? ____Yes ____No
   If yes, give an example: ____
   ____

Reading:

1. Do you experience frustration when reading? ____Yes ____No
   If yes, explain: ____
   ____

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
   ____ Integrating information ____ Reading/using maps

7. Do you have difficulty understanding the meaning of new words from the context?
   ____Yes ____No

8. When reading, do you often:
   ____ Reverse letters/numbers ____ Add letters
   ____ Confuse similar words ____ Skip lines
   ____ See letters/numbers out of order ____ Omit letters
   ____ Have difficulty focusing on the page
   ____ Reverse words or phrases

Math:

1. Do/did you have problems with basic math skills, such as:
   ____ Addition ____ Subtraction
   ____ Multiplication ____ Division
   ____ Time ____ Money
   ____ Managing personal accounts ____ Measurement

2. Do you have difficulty sequencing steps of a task in math?
   ____Yes ____No

3. Do you have difficulty with mathematical concepts? ____ Yes ____ No

Expressive Language:

1. Do you have difficulty organizing and expressing:
   Your thoughts and ideas? ____Yes ____No
   Your emotions? ____Yes ____No

2. Do you have difficulty retelling information you've read, seen or heard?
   ____Yes ____No
   If yes, explain: ____
   ____

3. Do you use a limited vocabulary when writing? ____Yes ____No

4. Do you mispronounce words? ____Yes ____No

5. Do you use words inappropriately? ____Yes ____No

6. Do you express yourself more effectively when: ____Writing ____Speaking

7. Do you experience problems retrieving words? ____Yes ____No

Learning Style:

1. Do you have problems understanding verbal information, such as:
   ____ Following verbal directions
   ____ Following a lecture
   ____ Misinterpreting what people are saying

2. Do you experience difficulty memorizing material (numbers, dates, names, factual information)? ____Yes ____No

3. Do you have problems retrieving information? ____Yes ____No

4. Do you have problems with directions, such as:
   ____ Left and right ____ North, south, east, west
   ____ Verbal instructions

5. Check any of the following which present difficulties in your *test taking experience*:
   ____ anxiety ____ insufficient time ____ multiple choice
   ____ true/false ____ matching ____ fill-in
   ____ short essay ____ long essay ____ calculations
   ____ spelling ____ grammar ____ organizing
   ____ memory ____ background noises ____ distraction
   ____ filling out scantron (bubbling)

In order to learn more about you, please describe as completely as possible the learning difficulties that you have experienced throughout your lifetime (three to four paragraphs in your own words and handwriting).

YOU MAY CONTINUE ON THE BACK