PLEASE READ THIS BEFORE COMPLETING A QUESTIONNAIRE

Policy on Assessment for Possible Disability

Undergraduate students who are not currently receiving services from Student Disability Services may be eligible to be assessed for a possible disability. Students must also have at least one of the following concerns to be eligible for assessment:

- a history of school problems;
- a GPA of 2.5 or lower;
- a low GPA in a specific subject that is impacting academic progress;
- inability to meet graduation requirements (such as WPA, Foreign Language etc); and/or
- on academic probation with the potential for academic disqualification.

Our purpose for assessment is to determine whether or not a potential disability is severe enough to qualify students to receive legal accommodations while enrolled at San Diego State University. We will not assess in order to qualify individuals for accommodation at other institutions, for accommodation at places of employment, or for accommodation for national standardized tests. Diagnoses made and accommodations authorized by Student Disability Services may not meet eligibility criteria at other institutions.

Graduate students and undergraduates who do not meet the criteria for assessment by the university may seek assessment from appropriate professionals in the community and supply documentation to Student Disability Services for determination of eligibility for services.

A student with an existing cognitive or psychological disability that can be documented should submit the documentation along with the disability questionnaire. Disability verification forms and the Disability Questionnaire can be downloaded from the Student Disability Services web site at www.sa.sdsu.edu/dss.

If you have any questions about our assessment policy, please contact us at 619-594-6473.
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.

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<th>Class</th>
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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 ___ Tasks too difficult
   ___ Physical handicap ___ Home environment
   ___ Limited ability ___ Lack of school interest
   ___ Emotional problems ___ Bad luck
   ___ Economic disadvantage ___ 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
   _____ Other: ____________________________
   _____ Outlining
   _____ Library resources
   _____ Multiple choice tests
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