

Regents' Center for Learning Disorders
At the University of Georgia

Case History

Information requested on this questionnaire is required as part of your evaluation. Please feel free to add as much information as you want and use additional 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

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_
Last First MI Preferred

Preferred Contact # \_\_\_\_\_

Permanent Mailing Address

Number and Street, Apartment Number, and/or P.O. Box
City State Zip Code Phone # at Permanent Address

Current Mailing Address, if different from the permanent mailing address

Number and Street, Apartment Number, and/or P.O. Box
City State Zip Code Phone # at Current Address

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_
Month Day Year

Gender [ ] Female [ ] Male

Ethnicity (optional) [ ] American Indian or Native American [ ] Asian or Pacific Islander [ ] Black or African American [ ] Hispanic [ ] Multiracial [ ] White [ ] Other \_\_\_\_\_

Marital Status [ ] never married/single [ ] married [ ] divorced [ ] widowed/widower

Are you [ ] right-handed [ ] left-handed [ ] ambidextrous

Have you ever been formally diagnosed with Attention Deficit Disorder (with or without hyperactivity)? [ ] yes [ ] no

Which: [ ] with hyperactivity [ ] without hyperactivity When? \_\_\_\_\_

Have you ever been formally diagnosed with a learning disability? [ ] yes [ ] no
When? \_\_\_\_\_

Date of your last psychological evaluation? \_\_\_\_\_ By whom? \_\_\_\_\_

## Educational Background

Elementary School(s) Attended	Public	Private	Grade Levels	City/State
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Middle/Junior High School(s) Attended	Public	Private	Grade Levels	City/State
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

High School(s) Attended	Public	Private	Grade Levels	City/State
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Did you or will you graduate high school?  yes  no    Graduation date \_\_\_\_\_

Diploma Type  college prep  technical/vocational  special ed certificate  ged

High school grade point average (cumulative GPA) \_\_\_\_\_

Did you repeat any grades in school?  yes  no    What grades? \_\_\_\_\_

Best S.A.T. scores (if taken)    Verbal \_\_\_\_\_ Math \_\_\_\_\_ Writing \_\_\_\_\_

Was test:  Timed  Extended Time  Other Accommodations \_\_\_\_\_

Best A.C.T. composite score (if taken): \_\_\_\_\_ Was test:  Timed  Extended Time  Other

Do you plan to take either test again?  yes  no    When? \_\_\_\_\_

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

Foreign Language  yes  no    # of courses \_\_\_\_\_ grades earned \_\_\_\_\_

What Language(s): \_\_\_\_\_

What things were hard for you to learn in elementary school (such as learning right and left, telling time, reciting the alphabet, recognizing the letters, learning the sounds of letters, writing, arithmetic, succeeding in physical education, writing cursive, making and keeping friends, etc.)?

\_\_\_\_\_

\_\_\_\_\_

What things were hard for you in junior high and high school (such as writing compositions, reading long assignments, sports, social skills, oral presentations, foreign language, algebra, geometry, etc.)?

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## College History

College Currently Attending \_\_\_\_\_ Current GPA: \_\_\_\_\_

Class Status  first year  second year  third year  fourth year  fifth year  graduate

Current Courses \_\_\_\_\_

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Previous Colleges \_\_\_\_\_ Dates: \_\_\_\_\_ GPA: \_\_\_\_\_

\_\_\_\_\_ Dates: \_\_\_\_\_ GPA: \_\_\_\_\_

Future College Plans (indicate anticipated dates) \_\_\_\_\_

What are your best subjects? \_\_\_\_\_

What are your poorest subjects? \_\_\_\_\_

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

Foreign Language  yes  no # of courses \_\_\_\_\_ grades earned \_\_\_\_\_

What Language(s): \_\_\_\_\_

Anticipated Graduation date \_\_\_\_\_ Major \_\_\_\_\_

List technical/trade schools or special programs attended (indicate dates)

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In college, have you taken or are you currently taking any learning support classes?

Math  97  99 Reading  99 English  98  99

## History of Learning Difficulties

What things are currently most difficult for you \_\_\_\_\_

\_\_\_\_\_

When was your learning problem first observed? \_\_\_\_\_

### Evaluations related to learning/attention difficulties (list chronologically)

Date	Examiner	Place of Evaluation	Diagnosis

Have you ever taken medication(s) related to your learning/attention problems?

List from most current

Dates Taken	Medication and Dosage	Did It Help?	Side Effects

## Special Education Services or Tutoring

Did you attend resource classes (special education)?     yes     no    Years: \_\_\_\_\_

Did you attend self-contained classes?     yes     no    Years: \_\_\_\_\_

Did you attend a special school?     yes     no    Years: \_\_\_\_\_

Name of school: \_\_\_\_\_

Did you attend other special programs?     yes     no

Specify type, duration and dates of attendance: \_\_\_\_\_

Describe tutoring you have had (subjects, hours/week, grade level) \_\_\_\_\_

\_\_\_\_\_

What help did you find the most beneficial and why? \_\_\_\_\_

What accommodations have you received?     extra time on exams     audio/electronic format

note takers     use of a calculator     test reader

word processor     private/quiet testing room

others: \_\_\_\_\_

## Current Plans

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

What is your purpose in seeking this evaluation? \_\_\_\_\_

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Describe how your learning problems affect you (such as in oral communication, listening and taking notes simultaneously, socially, in specific tasks such as spelling, self confidence, etc.)? \_\_\_\_\_

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What type of special services do you believe you will need in college and why? \_\_\_\_\_

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Describe your strengths as you see them: \_\_\_\_\_

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What do you enjoy doing in your spare time? \_\_\_\_\_

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

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What are you interested in studying? \_\_\_\_\_

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What do you plan to do after college? \_\_\_\_\_

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## Family Background

**Spousal Information** (if you are married): Name \_\_\_\_\_

Occupation: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**Do you have children?**  yes  no If yes, please provide:

Name	Age	Highest Grade Completed	Difficulties in Learning Or Other Disabilities (Describe)

**Father's Information** (pertains to your father)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Formally diagnosed with AD/HD?  yes  no Formally diagnosed with LD?  yes  no

Difficulties in learning?  yes  no Describe: \_\_\_\_\_

Other disabilities (e.g., physical, psychological)? (Describe) \_\_\_\_\_

Is your father:  right-handed  left-handed  ambidextrous

**Mother's Information** (pertains to your mother)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Formally diagnosed with AD/HD?  yes  no Formally diagnosed with LD?  yes  no

Difficulties in learning?  yes  no Describe: \_\_\_\_\_

Other disabilities (e.g., physical, psychological)? (Describe) \_\_\_\_\_

Is your mother:  right-handed  left-handed  ambidextrous

**Do you have sisters and brothers?**  yes  no If yes, please provide:

Sibling Name	Age	Highest Grade Completed	Difficulties in Learning Or Other Disabilities (Describe)

(add additional pages if needed)

### Other Significant Information About Your Family

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

Mental Health Disorders (e.g., depression, anxiety)  yes  no Who? \_\_\_\_\_ What? \_\_\_\_\_

Mental Retardation  yes  no Who? \_\_\_\_\_ What? \_\_\_\_\_

Epilepsy/Seizure Disorder  yes  no Who? \_\_\_\_\_ What? \_\_\_\_\_

Serious Chronic Illness (specify)  yes  no Who? \_\_\_\_\_ What? \_\_\_\_\_

Speech/Language Problems  yes  no Who? \_\_\_\_\_ What? \_\_\_\_\_

Substance Abuse  yes  no Who? \_\_\_\_\_ What? \_\_\_\_\_

What was your native language:  English  Spanish  other: \_\_\_\_\_

How often has your family moved? \_\_\_\_\_

### Birth History (pertains to *your mother's pregnancy history and your birth*)

**History of miscarriage?**  yes  no **Stillbirths?**  yes  no

Please indicate when miscarriages and/or stillbirths occurred in relation to your birth: \_\_\_\_\_

### Pregnancy with you:

Duration of pregnancy:  premature / how many weeks early? \_\_\_\_\_  
 normal / # of weeks \_\_\_\_\_  
 late / how many weeks late? \_\_\_\_\_

Bleeding:  yes  no Illness:  yes  no

Accidents:  yes  no Infections:  yes  no

Describe any unusual complications related to pregnancy: \_\_\_\_\_

Medications Taken During Pregnancy?  yes  no Please List: \_\_\_\_\_

Alcohol or drug use during pregnancy?  yes  no

### Circumstances of your birth:

Labor: False  yes  no Induced  yes  no

Anesthesia  yes  no Natural  yes  no

Type of Birth: Normal  yes  no Dry  yes  no

Forceps  yes  no Caesarean  yes  no

Breech  yes  no

Complications: \_\_\_\_\_

Length at Birth (inches) \_\_\_\_\_ Weight at Birth (lbs) \_\_\_\_\_ Apgar Scores \_\_\_\_\_

Color at Birth: 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 other unusual circumstances: \_\_\_\_\_

### Developmental History

#### At what age (in months) did you:

Sit alone \_\_\_\_\_ Say your first word \_\_\_\_\_

Walk alone \_\_\_\_\_ Understand speech \_\_\_\_\_

Use 2-word sentences \_\_\_\_\_ Stop using "baby" talk \_\_\_\_\_

#### Did your family, friends, teachers, etc., ever have difficulty understanding your speech?

yes  no If yes, please explain: \_\_\_\_\_

#### Did you receive speech therapy or work with a speech pathologist during childhood?

yes  no If yes, how long? \_\_\_\_\_

#### What things were hard for you to learn as a preschooler (such as buttoning, cutting with scissors, learning to ride a bike)? \_\_\_\_\_

#### Was Occupational Therapy (OT) required due to motor problems? yes no

If yes, how long? \_\_\_\_\_

**Did you tend to get in trouble frequently in school?**  yes  no

What for? \_\_\_\_\_

**Were you ever suspended or expelled from school?**  yes  no

What for? \_\_\_\_\_

## Medical History

### Have you ever had?

Measles Age: \_\_\_\_\_

Meningitis Age: \_\_\_\_\_

Encephalitis Age: \_\_\_\_\_

Whooping Cough Age: \_\_\_\_\_

Scarlet Fever Age: \_\_\_\_\_

Ear Infections Age: \_\_\_\_\_

Tubes placed in ears Age: \_\_\_\_\_

Chicken Pox Age: \_\_\_\_\_

Pneumonia Age: \_\_\_\_\_

Frequent Colds Age: \_\_\_\_\_

Allergies Age: \_\_\_\_\_

Others Age: \_\_\_\_\_

### List any accidents in which you received a blow to the head that required treatment

Age	Unconscious?	Duration of Unconsciousness	Describe Accident/Treatment
	<input type="checkbox"/> yes <input type="checkbox"/> no		
	<input type="checkbox"/> yes <input type="checkbox"/> no		
	<input type="checkbox"/> yes <input type="checkbox"/> no		

(use additional space/pages if needed)

**Have you ever had seizures?**  yes  no Age at 1<sup>st</sup> Seizure \_\_\_\_\_ Age at last seizure \_\_\_\_\_

Did you receive medication?  yes  no Specify: \_\_\_\_\_

Known cause for seizures? \_\_\_\_\_

**Were there any changes in thinking, behavior, or school performance following illnesses, blows to head or seizures?**  yes  no Describe: \_\_\_\_\_

\_\_\_\_\_

**Have you ever received a neurological exam?**    yes    no

EEG    yes    no      CT scan    yes    no      MRI scan    yes    no

Explain Diagnosis/Result: \_\_\_\_\_

**Have you ever had other injuries or accidents requiring medical treatment?**    yes    no

Please Describe: \_\_\_\_\_

**Have you ever been hospitalized?**    yes    no    When? \_\_\_\_\_

Length of hospitalization(s): \_\_\_\_\_ Purpose: \_\_\_\_\_

**Have you ever been involved in psychological counseling (family, group, or individual therapy)?**    yes    no    Age \_\_\_\_\_    How long? \_\_\_\_\_

Please Describe: \_\_\_\_\_

**Current Medical Condition**

**Describe your present health** \_\_\_\_\_

**Are you presently on medication, or have you been on medication in the last five years?**

yes    no    If yes, specify the medications and other information requested:

Medication	Amount	Frequency	Dates Taken	Reason

**Are you allergic to any drugs?**    yes    no    Please specify: \_\_\_\_\_

**How is your appetite?** \_\_\_\_\_

Do you have food allergies?    yes    no    Please specify: \_\_\_\_\_

Do you have seasonal allergies?    yes    no    Please specify: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_    Are you attempting to gain or lose weight? \_\_\_\_\_

**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    Describe: \_\_\_\_\_

**Do you wear glasses or contact lenses?**     yes     no    Date of last exam? \_\_\_\_\_

Purpose:     reading or seeing close-up     distance     strabismus     fusion/eye muscle balance  
 other \_\_\_\_\_

**Hearing Acuity Loss?**     yes     no

**Work History**

List all salaried and volunteer positions beginning with the most recent

Title	Responsibilities	ADHD/LD Affect Work?	Dates
		<input type="checkbox"/> yes <input type="checkbox"/> no	
		<input type="checkbox"/> yes <input type="checkbox"/> no	
		<input type="checkbox"/> yes <input type="checkbox"/> no	
		<input type="checkbox"/> yes <input type="checkbox"/> no	

**Legal History** (list any current or past legal difficulties, involvement in lawsuits, arrests, dui's, etc.):

\_\_\_\_\_

**Driving History** (list # of accidents, speeding tickets, concerns, etc.)

\_\_\_\_\_

**Additional information you believe is important for us to know:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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