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
	☐	☐		
	☐	☐		
	☐	☐		

Middle/Junior High School(s) Attended	Public	Private	Grade Levels	City/State
	☐	☐		
	☐	☐		
	☐	☐		

High School(s) Attended	Public	Private	Grade Levels	City/State
	☐	☐		
	☐	☐		
	☐	☐		

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?

_____

_____

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

_____

_____

College History

College Currently Attending _____Current GPA:_____

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

Current Courses _____

_____

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)

_____

_____

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? _____

_____

_____

Describe how your learning problems affect you:

_____

_____

_____

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

_____

_____

Describe your strengths as you see them: _____

_____

_____

What do you enjoy doing in your spare time? _____

_____

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

_____

What are you interested in studying? _____

_____

What do you plan to do after college? _____

_____

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
	☐ yes ☐ no		
	☐ yes ☐ no		
	☐ yes ☐ no		

(use additional space/pages if needed)

Have you ever had seizures? ☐ yes ☐ no Age at 1st 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
		☐ yes ☐ no	
		☐ yes ☐ no	
		☐ yes ☐ no	
		☐ yes ☐ 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