**Disability Services**
(660)785-4478 phone
(660)785-4011 fax

**McKinney Building**
100 East Normal
Kirksville, MO 63501

# Client Information Form for Disability Services (DSO)

Name: ______________________ Date: ______________________

Banner ID Number: ______________________ Date of Birth: ______________________

Telephone Number (cell): ______________________ Telephone (local): ______________________

Campus Address: ______________________ E-mail Address: ______________________

Year in School: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate

## Personal Information

**My major is** ______________________ **My GPA is** ______________________

**English is my 1st language**: ☐ Yes ☐ No, my first language is ______________________

**I am currently**:
- ☐ On probation
- ☐ Progressing as expected
- ☐ Progressing worse than expected
- ☐ Progressing better than expected

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**1**. Please describe why you contacted the Disability Services Office: ______________________

______________________

______________________

**2**. I work while attending school (if yes, describe your position and indicate how many hours you work per week): ☐ Yes ☐ No ______________________

______________________

______________________

**3**. There have been significant changes in my life during the past year (if yes, please provide additional details):

☐ Yes ☐ No ______________________

______________________

______________________

## Educational Information

**1**. Have you ever repeated a grade? ☐ Yes ☐ No If yes, please list the grade(s): ___________________

**2**. Have you ever skipped a grade? ☐ Yes ☐ No If yes, please list the grade(s): ___________________

**3**. Have you ever been enrolled in any special education or remedial classes in elementary, middle, or high school (if yes, please describe)? ☐ Yes ☐ No ___________________________________________________

___________________________________________________________________________________________

**4**. Have you received accommodations or special services at a college or university (if yes, please describe)?

☐ Yes ☐ No ___________________________________________________________________________________

**5**. Please describe your career goals and interests after completing college: ________________________________

___________________________________________________________________________________________

**6**. Have you ever been suspended (if yes, please provide details)? ☐ Yes ☐ No ______________________

___________________________________________________________________________________________

**7**. Have you ever been on academic probation (if yes, please provide details)? ☐ Yes ☐ No ____________

___________________________________________________________________________________________

**8**. List the high schools and colleges you have previously attended:

| School | City | Dates Attended | Degree Earned | GPA |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**9**. ACT/SAT Scores: ___________________ Graduate Test Scores (GRE, GMAT, etc.): __________________

## History and Nature of Disability

**1**. Have you ever been diagnosed with a learning disability? ☐ Yes ☐ No If yes, when? ______________

**2**. Describe your learning difficulties or academic challenges: ___________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

**3**. Indicate the area(s) in which you experience academic difficulty:

☐ Reading ☐ Writing ☐ Mathematics ☐ Spelling ☐ Note taking ☐ Handwriting ☐ Other, please describe: ________________________________________

When did you first notice these difficulties? ________________________________________

**4**. Describe any difficulties you experience concentrating or paying attention: ____________________

________________________________________________________________________________

**5**. Indicate the area(s) in which you experience difficulty:

☐ Memory ☐ Organization ☐ Time Management ☐ Planning ☐ Initiating Tasks ☐ Other, please describe: ________________________________________

When did you first notice these difficulties? ________________________________________

**6**. Describe your academic strengths: ________________________________________

________________________________________________________________________________

**7**. On average, how many hours per week do you study?

☐ Less than 10 ☐ 10 – 15 ☐ 15 – 20 ☐ 20 – 25 ☐ 25 – 30 ☐ 30 – 35 ☐ More than 35

**8**. How would you rate your study skills? ☐ Below average ☐ Average ☐ Above average

**9**. How much effort do you put into studying? ☐ Below average ☐ Average ☐ Above average

**10**. Do you believe there is room for improvement in your class attendance? ☐ Yes ☐ No

**11**. Please describe other demands on your time (such as internships, family, activities, athletics, fraternities, sororities, etc.): ________________________________________

________________________________________________________________________________

## Family Educational History

**1**. Has anyone in your family been diagnosed with a learning disability (if yes, please provide details)?

☐ Yes ☐ No ________________________________________

**2**. Has anyone in your family been diagnosed with ADD or ADHD (if yes, please provide details)?

☐ Yes ☐ No ________________________________________

**3**. Please list the education levels and occupations of your parents and siblings:

| | Highest Education Level | Current Occupation |
|---|---|---|
| **Mother** | | |
| **Father** | | |
| **Sibling** | | |
| **Sibling** | | |
| **Sibling** | | |

## Medical History

**1**. To your knowledge, did you experience any trauma or complications at birth (if yes, please provide details)?

☐ Yes ☐ No ____________________________________________________________

____________________________________________________________________________

**2**. Did you have any major childhood illnesses, diseases, or surgeries (if yes, please provide details)? ________

☐ Yes ☐ No ____________________________________________________________

____________________________________________________________________________

**3**. Have you ever been diagnosed with a psychiatric disorder (if yes, please provide details)? ______________

☐ Yes ☐ No ____________________________________________________________

____________________________________________________________________________

**4**. Have you in the past or are you currently receiving formal counseling (if yes, please provide details)? _____

☐ Yes ☐ No ____________________________________________________________

____________________________________________________________________________

**5**. Have you ever experienced head trauma and/or lost consciousness (if yes, please provide details)? ________

☐ Yes ☐ No ____________________________________________________________

____________________________________________________________________________

**6**. Have you ever had a seizure (if yes, please provide details)? ______________________________________

☐ Yes ☐ No ____________________________________________________________

____________________________________________________________________________

**7**. Are you currently being treated for any medical condition (if yes, please provide details)? ______________

☐ Yes ☐ No ______________________________________________________________________________

______________________________________________________________________________________________

**8**. Have you ever been diagnosed with ADD or ADHD (if yes, please provide details)? __________________

☐ Yes ☐ No ______________________________________________________________________________

______________________________________________________________________________________________

**9**. Are you currently taking any prescription medications (if yes, please provide details)? _________________

☐ Yes ☐ No ______________________________________________________________________________

______________________________________________________________________________________________

**10**. Do you have any significant vision problems (if yes, please provide details)? ________________________

☐ Yes ☐ No ______________________________________________________________________________

______________________________________________________________________________________________

**11**. Do you have any significant hearing problems (if yes, please provide details)? _______________________

☐ Yes ☐ No ______________________________________________________________________________

______________________________________________________________________________________________

**12**. How many alcoholic beverages do you drink per week? __________________________________________

__________________________________________________ ____________________________________
Student's Signature Date