

**Office of Student Access
and Disability Services**
(660)785-4478 phone
(660)785-4490 fax

**Pickler Memorial
Library 109A**
100 East Normal
Kirksville, MO 63501

Client Information Form for Student Access & Disabilities

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

1. Please describe why you contacted the Office of Student Access and Disability Services / what is the barrier you are experiencing accessing your classroom education: _____

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 high school, college or university (if yes, please describe)? Yes No _____

5. If you have not received accommodations previously, what accommodations are you requesting to remove a barrier to allow access to the classroom/curriculum? _____

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 and accommodations that have helped in the past: _____

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

Reading Writing Mathematics Spelling Note taking Handwriting Other

Please describe if Other: _____

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 if Other: _____

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 1		
Sibling 2		
Sibling 3		

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 _____