



How did you find out about our services: \_\_\_\_\_

\_\_\_\_\_

What is your disability: \_\_\_\_\_

\_\_\_\_\_

How does your disability limit you: \_\_\_\_\_

\_\_\_\_\_

What are your strengths? \_\_\_\_\_

List

Medications: \_\_\_\_\_

\_\_\_\_\_

Have you had any problems with Concentration, Attention, and Hyperactivity?

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

\_\_\_\_\_

Have you received disability support services from any other College or University: \_\_\_\_ Yes \_\_\_\_ No

If yes, explain: \_\_\_\_\_

Family issues related to school participation: \_\_\_\_\_

Employment issues related to school participation: \_\_\_\_\_

Date Graduated From High School: \_\_\_\_\_ Type of Diploma: \_\_\_\_\_

Proficiency Tests Taken/Outcome: \_\_\_\_\_

Accommodations received in high school: \_\_\_\_\_

Planned course of study at WNC: \_\_\_\_\_

Goals for attending college: \_\_\_\_\_

**Health Information:**

Do you have a vision problem: \_\_\_Yes \_\_\_No

Glasses: \_\_\_Yes \_\_\_No    Contacts: \_\_\_Yes \_\_\_No

Have you had a visual exam in the last two years: \_\_\_Yes \_\_\_No

Results: \_\_\_\_\_

Do you have hearing problems: \_\_\_Yes \_\_\_No

Hearing aids: \_\_\_Yes \_\_\_No

Have you had a hearing exam in the last 5 years: \_\_\_Yes \_\_\_No

Results: \_\_\_\_\_

Are you on any medication at the current time: \_\_\_Yes \_\_\_No

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

Have you ever been on a long-term program of medication: \_\_\_Yes \_\_\_No

Explain: \_\_\_\_\_

Have you had:	<b>Yes</b>	<b>No</b>
Head injuries	_____	_____
Seizures	_____	_____
Serious illness/injuries	_____	_____
Emotional problems	_____	_____
Learning disabilities	_____	_____
ADD	_____	_____
ADHD	_____	_____
Substance Abuse	_____	_____
Hospitalization	_____	_____
Counseling	_____	_____

Comments: \_\_\_\_\_

\_\_\_\_\_

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