

California Community Colleges  
Learning Disabilities Services

**CONSENT FORM**

The Chancellor's Office of the California Community Colleges is committed to protecting the rights of persons who are assessed for learning disabilities (LD) eligibility. The information below is provided so that you can decide whether to participate in the LD eligibility assessment.

You are being asked to complete several assessment instruments that will help in determining your eligibility for learning disabilities services through Disabled Student Services Learning Disabilities Programs. The assessments might include tests of ability, achievement, learning skills, and surveys.

The results of these tests are **strictly confidential**. The scores are used in the determination of LD eligibility and in the development of appropriate educational programs. The scores may be maintained in computer files in addition to the test booklet. Descriptive information and test scores may be used in research projects approved by the Chancellor's Office. To ensure your privacy, this information will not be personally identifiable.

If you have any questions, ask for clarification. In addition, if you believe that the assessment or eligibility determination is invalid, you may challenge the results through a petition process.

The Information Practices Act of 1977 (Civil Code Sections 1798, et seq.) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals. The Community College District and the State of California use information requested on this form for the sole purpose of identifying the student authorized to receive special services. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be transferred to other state and public agencies; however, disclosure to these parties is done in strict accordance with current statutes regarding confidentiality. Providing personal information is strictly voluntary.

Limits to confidentiality include threats to harm self, others, or cases of child abuse or elder abuse. As mandated reporters, we are required to report incidences where individuals are in harm's way.

By signing this consent form you agree to participate in the assessment activities described above and acknowledge the use of the information as described.

**I understand this information and agree to complete the assessment to determine eligibility for learning disabilities services.**

YES                      NO

Print Name \_\_\_\_\_ ID# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# INTAKE INTERVIEW

## LEARNING DISABILITIES SERVICES

**STUDENTS:** The Chancellor's Office of the community college system is required to gather and maintain certain student information. This information is the ethnicity, gender, age, and disability status of students requesting services through the disabled student services program.

Providing this information is strictly voluntary for you. However, the college is required to complete each item since this form is the only means which the college has for gathering the required information. For this reason, we ask your assistance in completing the form.

### DESCRIPTIVE INFORMATION

Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Contact Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Can you be contacted at work?     Yes     No                      Work Phone \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Place of Birth \_\_\_\_\_

1. How do you describe yourself and your mother/guardian? (Please select one for each category.)

Self

Mother/Guardian

### REFERRAL INFORMATION

2. Who referred you to our program and why? \_\_\_\_\_

(Name)

(Agency)

\_\_\_\_\_  
(Reason)

3. Why do you want to be evaluated for learning disabilities eligibility? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. In what academic areas have you experienced difficulty? (Check all that apply and please describe)

Reading/reading rate \_\_\_\_\_

\_\_\_\_\_

Math \_\_\_\_\_

\_\_\_\_\_

Writing skills \_\_\_\_\_

\_\_\_\_\_

Spelling \_\_\_\_\_

\_\_\_\_\_

Study skills \_\_\_\_\_

\_\_\_\_\_

Following along/taking notes during lecture \_\_\_\_\_

\_\_\_\_\_

Retaining information \_\_\_\_\_

\_\_\_\_\_

Completing assignments on time \_\_\_\_\_

\_\_\_\_\_

Taking tests \_\_\_\_\_

\_\_\_\_\_

Computer Skills \_\_\_\_\_

\_\_\_\_\_

Motivation/self-confidence in school \_\_\_\_\_

\_\_\_\_\_

5. Describe any school-related strategies you have attempted \_\_\_\_\_

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6. List the highest level English and Math courses you have attempted/completed.

Class	Level (e.g., remedial, AA/AS, transfer)	Grade Received	Date Completed
English: _____	_____	_____	_____
Math: _____	_____	_____	_____

7. Have you ever had difficulties with any of the following:

a. attention/concentration?

- Easily distracted?  Yes  No      Often disorganized?  Yes  No  
Focusing in class?  Yes  No      Staying on task while studying?  Yes  No  
Often lose items?  Yes  No      Daydream often/mind wanders?  Yes  No

b. hyperactivity?

- Often fidgeting?  Yes  No      Difficulty sitting still?  Yes  No

c. do you experience these difficulties:  at school?  at work?  at home?

8. Have you ever been evaluated for Attention Deficit (Hyperactivity) Disorder (ADHD)?  Yes  No

• If **yes**, when and by whom? \_\_\_\_\_

What were the results? \_\_\_\_\_

9. Are or were you a client of the Department of Rehabilitation?  Yes  No

• If **yes**, please identify:

a. What is your disability according to Dept. of Rehab.? \_\_\_\_\_

b. Rehabilitation counselor's name \_\_\_\_\_ Phone \_\_\_\_\_

c. What is your rehabilitation plan? \_\_\_\_\_

10. Are or were you a client of the Regional Center?  Yes  No

• If yes, what is the name of your case worker? \_\_\_\_\_

11. Are or were you receiving services/support from any of the following? (Check all that apply.)

- \_\_\_\_\_ DSP&S      \_\_\_\_\_ EOPS      \_\_\_\_\_ CalWorks      \_\_\_\_\_ Financial Aid  
\_\_\_\_\_ SSDI/SSI      \_\_\_\_\_ Veteran      \_\_\_\_\_ Other: \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

12. Were there any medical or developmental problems before or after your birth or during the birth process?

Yes       No

• If **yes**, explain \_\_\_\_\_

13. To your knowledge, was there anything unusual about your early development, e.g., delayed speech; late crawling or walking; problems using scissors, printing, or writing?

Yes       No

• If **yes**, explain \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

14. Did your family provide a stimulating environment in terms of each of the following:

a. frequent exposure to spoken language, did people talk at home?  Yes       No

b. availability of books, magazines, or other print materials       Yes       No

c. someone who read to you?       Yes       No

d. enrichment experiences (e.g., museums, libraries, theatre, etc.)  Yes       No

• Please explain \_\_\_\_\_

15. Does anyone in your family have learning difficulties?       Yes       No

• If **yes**, describe \_\_\_\_\_

\_\_\_\_\_

16. Does anyone in your family have any other type of disability (e.g., physical, medical, emotional, vision or hearing loss)?       Yes       No

• If **yes**, describe \_\_\_\_\_

\_\_\_\_\_

17. Describe any family and/or personal issues which you feel have affected your learning/education *in the past*.

\_\_\_\_\_

\_\_\_\_\_

18. Describe any family and/or personal issues which are impacting your learning/education *at this time*.

\_\_\_\_\_

\_\_\_\_\_

**HEALTH INFORMATION**

19. Do you have problems with your vision?  Yes  No  
• If **yes**, describe (nearsighted, farsighted, etc.): \_\_\_\_\_

20. Do you wear glasses or contact lenses? (Circle one if yes.)  Yes  No

21. Have you had an eye exam within the last two years?  Yes  No  
• If **yes**, when? \_\_\_\_\_

22. Do you have problems with your hearing?  Yes  No  
• If **yes**, describe: \_\_\_\_\_

23. Did you have frequent ear infections or tubes in your ears?  Yes  No

24. Do you wear a hearing aid?  Yes  No

25. Have you had a hearing exam within the last five years?  Yes  No  
• If **yes**, when? \_\_\_\_\_

26. Do you have allergies or asthma? (Circle one or both if yes.)  Yes  No  
• If **yes**, please answer the following questions:  
a. Describe: \_\_\_\_\_  
b. How do the allergies, asthma, and/or medications influence your classwork? \_\_\_\_\_  
\_\_\_\_\_

27. Are you on any medication at the present time?  Yes  No  
• If **yes**, please identify:

a. Name(s) of medication(s) \_\_\_\_\_  
\_\_\_\_\_

b. Dosage \_\_\_\_\_

c. For what condition(s) \_\_\_\_\_

d. Side effects \_\_\_\_\_

28. Have you ever been on a long-term program of medication?  Yes  No  
• If **yes**, describe \_\_\_\_\_  
\_\_\_\_\_

29. a. Have you ever had a head injury?  Yes  No

b. Have you ever had a neurological exam (e.g., CAT scan, MRI)?  Yes  No

c. Have you ever been unconscious due to illness or injury?  Yes  No

d. Have you ever had a concussion?  Yes  No

• If **yes to a, b, c, or d**, please answer the following questions:

At what age(s)? \_\_\_\_\_ Were you hospitalized?  Yes  No

Please explain \_\_\_\_\_

30. Have you ever had seizures?  Yes  No

• If **yes**, specify when and describe: \_\_\_\_\_

31. Have you ever had any serious injuries or illnesses?  Yes  No

• If **yes**, specify when and please describe their impact on your education: \_\_\_\_\_

32. Do you have a history of or current mental health or psychological concerns?  Yes  No

• If **yes**, please answer the following questions:

a. Have you participated in mental health or personal counseling?  Yes  No

b. Have you engaged in self-injurious behaviors?  Yes  No

c. Have you engaged in suicidal thoughts/behaviors/attempts?  Yes  No

d. Were you ever hospitalized for mental health concerns?  Yes  No

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

\_\_\_\_\_

\_\_\_\_\_

33. Do you have a history of alcohol, drug, or substance abuse?  Yes  No

• If **yes**, please answer the following questions:

a. Have you participated in counseling for substance abuse?  Yes  No

b. Have you been treated as an outpatient?  Yes  No

c. Were you ever hospitalized for substance abuse?  Yes  No

d. For how long have you maintained sobriety? \_\_\_\_\_

34. What is your current substance use? \_\_\_\_\_

### **LIFE SKILLS AND WORK HISTORY**

35. Describe your current living situation \_\_\_\_\_

36. What are your day-to-day responsibilities in the home? \_\_\_\_\_

37. Are you currently employed?  Yes  No

• If **yes**, please describe current employment:

a. Where? \_\_\_\_\_

b. Job Duties? \_\_\_\_\_

c. Number of hours per week/weekly work schedule? \_\_\_\_\_

d. How long have you had this job? \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Weeks

e. If any, what difficulties have you experienced in your work environment?

\_\_\_\_\_

38. Describe any previous jobs, length of employment, job duties, and reason job ended. \_\_\_\_\_

\_\_\_\_\_

### **EDUCATIONAL INFORMATION**

39. As far as you can recall, when did you first start having problems in school?

\_\_\_\_\_

40. Did you frequently change schools within elementary or secondary school?  Yes  No

• If **yes**, explain: \_\_\_\_\_

\_\_\_\_\_

41. Were you retained in school (i.e., held back to repeat a grade) or was it suggested?  Yes  No

• If **yes**, what grade(s) and why? \_\_\_\_\_

42. Were you ever tested *or referred* for eligibility in special education prior to college?  Yes  No

• If **yes**, when and why? \_\_\_\_\_

43. Have you ever been in special education, remedial, or gifted classes?  Yes  No

• If **yes**, what type of classes? (Check all that apply.)

Special Day Class (SDC)                      Resource Program (RSP)                      Remedial Classes

Speech and Language Services                      Gifted                      504 Plan

Other (specialized tutoring, pulled out of classes)

• If you were in special education or remedial classes, in what high school classes were you mainstreamed? \_\_\_\_\_

44. What other school-related activities or issues influenced your academics (e.g. sports, clubs, etc.)?

\_\_\_\_\_

45. Did you drop out of school between kindergarten and 12th grade?  Yes  No

• If **yes**, please answer the following questions:

a. in what grade(s)? \_\_\_\_\_ For what reasons? \_\_\_\_\_

46. Are you a high school graduate?  Yes  No

• If **yes**, a. list name and location of high school: \_\_\_\_\_

b. date of graduation: \_\_\_\_\_

• If **no**, did you complete a GED or CA HS Proficiency Exam?  Yes  No

If **yes**, when? \_\_\_\_\_

47. Have you attended any other college or university?  Yes  No

• If **yes**, where? \_\_\_\_\_

• If **yes**, are your transcripts on file for review? \_\_\_\_\_

48. For how many semesters/quarters have you attended college? \_\_\_\_\_

49. How many units have you earned? \_\_\_\_\_

50. How many units (hours) are you currently taking? \_\_\_\_\_ Units (hours)

51. Are you required to take a certain number of units?  Yes  No

• If **yes**, how many units and why? \_\_\_\_\_

52. Are you on academic or progress probation?  Yes  No

• If **yes**, why? \_\_\_\_\_

53. List all of your current classes. Describe any difficulties you are experiencing in each. How much time do you spend each week (including Saturday and Sunday) studying and preparing for each of these classes?

Class (units)	Describe Difficulties	Weekly Study Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

54. Have you discussed your difficulties with the instructor or with a counselor?  Yes  No

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55. What college support services have you used? \_\_\_\_\_

56. In what type(s) of classes have you done well? \_\_\_\_\_

57. What are your goals for attending college? \_\_\_\_\_

College Major \_\_\_\_\_ College Counselor \_\_\_\_\_

### **CULTURAL AND LINGUISTIC INFORMATION**

(In completing this section it may be appropriate to consult with family members who may have more in-depth information.)

58. How long have you lived in the United States? \_\_\_\_\_

59. Do you periodically move back and forth to the United States?  Yes  No

• If **yes**, describe: \_\_\_\_\_

60. Were you raised in the culture of the United States?  Yes  No  
(includes exposure to schools, television, libraries, etc.)

61. Is English your first and only language?  Yes  No

• If **no**, please answer the following questions:

a. What other language(s) do you know? \_\_\_\_\_

b. What language did you learn first? \_\_\_\_\_

c. In which language do you have greatest oral fluency, that is, ability to discuss college-level materials, or are you equal in both (or all)? \_\_\_\_\_

d. In which language do you have greatest written fluency, that is, ability to write essays at a college-level, or are you equal in both (or all)? \_\_\_\_\_

e. In which language do you have greatest reading fluency, that is, ability to read textbooks at a college-level, or are you equal in both (or all)? \_\_\_\_\_

• If you answered **YES** to question 61, **STOP!**

• If you answered **NO** to question 61 and possess greater or equal fluency in another language, complete the following Culturally/Linguistically Diverse (CLD) supplemental interview.

• If your first language is English, but you did not grow up with exposure to U.S. culture, please complete CLD interview questions 1- 5 and then stop.

## Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name	Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.		Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?						
3. How often do you have problems remembering appointments or obligations?						
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?						
<b>Part A</b>						
7. How often do you make careless mistakes when you have to work on a boring or difficult project?						
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
10. How often do you misplace or have difficulty finding things at home or at work?						
11. How often are you distracted by activity or noise around you?						
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
13. How often do you feel restless or fidgety?						
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?						
15. How often do you find yourself talking too much when you are in social situations?						
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
17. How often do you have difficulty waiting your turn in situations when turn taking is required?						
18. How often do you interrupt others when they are busy?						
<b>Part B</b>						