INSTITUTE FOR LEARNING AND DEVELOPMENT

Pathways to Success for All Learners

LEARNING NEEDS ASSESSMENT

The following information will help us to develop a clearer picture of your strengths and weaknesses and assist us in helping you to meet your needs.

Please fill out this questionnaire as best you can. Please indicate with N/A those items that do not apply to you. Please Print.

Date_____

Name_____

Date of Birth _____ **Age** ____ **SS#** _____ - ____ - _____

Home Address _____
Street City Zip

Telephone: **Home** ( ) _____

Work ( ) _____

Cell ( ) _____

E-mail Address: _____

***Insurance Company** _____ **Subscriber #** _____ **Group #** _____

Please list and describe your current work or school situation:

How did you hear about the Institute for Learning and Development?

Please describe the reasons for this referral. How can we help you?

- *Neuropsychological testing and psychotherapy are often partially covered by insurance. However, educational testing is not reimbursable by insurance companies. Direct payment is therefore requested. We will be happy to provide any additional documentation you may need if you submit the bill to your insurance company.*

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF EACH VISIT.

Thank you for your cooperation. **(Your signature)** _____

ILD has a non-profit partner! Research ILD is dedicated to research and development of innovative techniques for helping students learn how to learn. Research ILD also trains educators to appreciate and maximize students' unique learning styles, and our growing scholarship program provides access to ILD's resources for those who would otherwise be unable to afford our services. **The exemplary work of Research ILD ensures that ILD's services are effective!**

BACKGROUND LEARNING HISTORY

Highest Level of Education Completed: _____
High School Attended: _____ College Attended: _____
Please describe yourself as a student:

_____

_____

_____

Please check at which grade levels difficulties/problems were evident in these areas.
Provide comments as necessary.

	Elem/Middle	High School	College	Comments
Attention				
Behavior				
Gross Motor Skills				
Fine Motor Skills				
Oral Expression				
Written Expression				
Organization				
Memory				
Reading Words: Decoding				
Reading Comprehension				
Spelling				
Math Computation				
Math: Problem Solving				
Following directions				
Completing Homework/Tasks				
Test Performance				

Please describe any other learning problems not already noted above. Include any areas of difficulty as a young child, such as in language or motor skills.

EVALUATION/SERVICE HISTORY

Have you been evaluated previously? Yes No

If so, when and where? _____

Diagnosis:

No specific diagnosis ____ Learning disability ____

ADHD (with or without hyperactivity ____ Depression ____

Speech and/or language disability ____ Adjustment disorder ____

Anxiety disorder ____ Other: _____

What services were implemented as a result of this evaluation?

Were these services helpful? Yes No
Please explain:

Are you currently receiving any educational or counseling services? Yes No
For what purpose?

Counselor's Name _____ Telephone ( ) _____

Previous Counseling? _____ Counselor's name or facility:_____

FAMILY HISTORY

Mother's Name _____ Age _____ Occupation _____

Father's Name _____ Age _____ Occupation _____

Were you adopted? Yes No Number of Siblings _____

Marital status _____ Number of Children _____

Are your parents divorced? Yes No Are your parent(s) deceased? Yes No

What is your current living situation?

Living alone __

Living with a friend __

Living in a dormitory __

Living with a spouse __

Living with parent (s) __

Have any family members or relatives had a history of or shown evidence of school difficulties or learning problems (e.g. dropped out of school, repeated a grade, history of poor grades, attentional difficulties)?
Please explain:

Have any family members or relatives had a history or shown evidence of behavioral or emotional problems (e.g. anxiety disorders, depression, schizophrenia, substance abuse, alcoholism, obsessive compulsive disorder, physical/sexual abuse)? Please explain.

Please describe any recent or current family stresses (e.g. unemployment, health problems, losses, changes in work schedules, chronic conflicts, etc.).

MEDICAL HISTORY

Are you currently taking any medication(s)? Yes No

Name of medication(s) and dosage _____

Who prescribed the medication(s)? _____ When? _____

Reason(s) _____

Side effects or concerns about the medication(s) _____

Please list any medications that you have taken in the past.

Do you have routine health examinations? Yes No

Do you have routine eye and ear examinations? Yes No

Please describe any past or current health issues (e.g. recurrent ear infections, stomach aches, migraine headaches, asthma, diabetes, surgery, tics, etc.). Note if any of these conditions have resulted in prolonged isolation or school or work absences.