

Date Received: \_\_\_\_\_  
Received by: \_\_\_\_\_

Moraine Valley Community College  
Center for Disability Services (CDS)  
Program Intake Information Questionnaire  
~ To be completed by the student ~

(Please print/write clearly)

**Personal Information**

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Apartment # \_\_\_\_\_

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

Phone # (Home) \_\_\_\_\_ Alternate # \_\_\_\_\_

E-Mail address \_\_\_\_\_

How were you referred to CDS?

\_\_\_\_\_ Counselor                      \_\_\_\_\_ Community Agency/ORS                      \_\_\_\_\_ Self  
\_\_\_\_\_ Parent                              \_\_\_\_\_ Staff                                              \_\_\_\_\_ Instructor

**DIRECTIONS:** While **voluntary**, the answers you provide on this Program Intake Information Questionnaire will be extremely valuable in determining how we may best assist you. Please answer all questions to the best of your ability. Information gathered on this form is considered **confidential** and will not be shared with anyone without your permission.

**Background Information – Learning**

1. What is the primary language spoken in your home? \_\_\_\_\_

a. If **not** English – How old were you when you began to learn English? \_\_\_\_\_

2. What is your learning style? (Please check all that apply)

\_\_\_\_\_ Visual, I learn best by what I see or watching demonstrations.  
\_\_\_\_\_ Oral, I learn best by what I hear or listening to a lecture.  
\_\_\_\_\_ Kinesthetic, I learn best by getting hands on experience.  
\_\_\_\_\_ None of the above responses fit my learning style. I learn best \_\_\_\_\_

3. What study techniques do you currently use?

|                           |                           |                                     |
|---------------------------|---------------------------|-------------------------------------|
| _____ Quiet setting       | _____ Paraphrasing        | _____ Regular study schedule        |
| _____ Mnemonics           | _____ Study group/partner | _____ Long-term planning            |
| _____ Tutor sessions      | _____ Outlining text      | _____ Review of notes               |
| _____ Daily planner       | _____ Flashcards          | _____ Identifying key points        |
| _____ Highlighting        | _____ Marginal notes      | _____ Assignment notebook           |
| _____ Rewrite class notes | _____ Charts & diagrams   | _____ Other (please describe below) |

4. Which of the items listed below best describe your concentration and attention in class and/or when studying or taking a test? (Check all that apply)

Anxious                       Fidgety                       Distractible  
 Short attention span                       Difficulty recalling                       Test anxiety  
 Other (please describe) \_\_\_\_\_

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5. Approximately how much time do you spend studying **each day**? \_\_\_\_\_

6. After you have studied for a test, do you have a hard time remembering any of the following? (Check all that apply)

Topics                       Ideas                       Specific details  
 Names                       Dates                       Other (specify) \_\_\_\_\_

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7. Which areas associated with writing do you find difficult? (Check all that apply)

Spelling                       Grammar                       Punctuation  
 Handwriting                       Sentence structure                       Paragraph structure  
 Finding a topic or idea                       Putting ideas down on paper  
 Researching a topic                       Organizing                       Typing  
 Other (specify) \_\_\_\_\_

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\*What was the last level of English you were taught? \_\_\_\_\_

8. Which areas associated with math do you find difficult? (Check all that apply)

Calculation                       Word problems                       Formulas

\*What was the last level of math you were taught? \_\_\_\_\_

9. Which areas associated with reading do you find difficult? (Check all that apply)

Speed                       Comprehension                       Phonics

10. Of the following, check those areas with which you have difficulty. (Check all that apply)

|                                                           |                                                                      |
|-----------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Understanding class lectures     | <input type="checkbox"/> Note-taking                                 |
| <input type="checkbox"/> Paying attention                 | <input type="checkbox"/> Being prepared for class and/or exams       |
| <input type="checkbox"/> Participating in class           | <input type="checkbox"/> Talking to teachers                         |
| <input type="checkbox"/> Asking for help                  | <input type="checkbox"/> Procrastination                             |
| <input type="checkbox"/> Meeting new people               | <input type="checkbox"/> Reversing letter or numbers                 |
| <input type="checkbox"/> Beginning assignments            | <input type="checkbox"/> Keeping up with assignments                 |
| <input type="checkbox"/> Budgeting time                   | <input type="checkbox"/> Completing assignments                      |
| <input type="checkbox"/> Keeping appointments             | <input type="checkbox"/> Family commitments                          |
| <input type="checkbox"/> Over-extended with activities    | <input type="checkbox"/> Frequent absences                           |
| <input type="checkbox"/> Over-extended with work          | <input type="checkbox"/> Cramming for tests                          |
| <input type="checkbox"/> Not finishing test               | <input type="checkbox"/> Reading/following directions or maps        |
| <input type="checkbox"/> Processing information slowly    | <input type="checkbox"/> Writing speed                               |
| <input type="checkbox"/> Putting steps of a task in order | <input type="checkbox"/> Becoming easily frustrated with school work |
| <input type="checkbox"/> Verbally expressing thoughts     | <input type="checkbox"/> Other (specify) _____                       |

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11. Describe how you study for a test/exam \_\_\_\_\_

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12. What are your strengths? (Please list below)

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13. What are your areas of concern? (Please list below)

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### **Background Information – Academic**

1. Did you attend a preschool, nursery school, or kindergarten? \_\_\_\_\_ Yes \_\_\_\_\_ No

2. Did you ever repeat a grade? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

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3. How many elementary schools did you attend (grades K-5)? \_\_\_\_\_

How many junior high or middle schools did you attend (grades 6-8)? \_\_\_\_\_

How many high schools did you attend (grades 9-12)? \_\_\_\_\_

What high school did you most recently attend or graduate from? \_\_\_\_\_

4. Did you: \_\_\_\_\_ Graduate from high school? Year? \_\_\_\_\_

\_\_\_\_\_ Earn a GED? Year? \_\_\_\_\_

\*Note: if you earned a GED, please skip to question # 8

5. On the average, how many days were you absent each year while in high school? \_\_\_\_\_

6. What was the most frequent reason for you absences?

\_\_\_\_\_ Illness \_\_\_\_\_ Disciplinary action \_\_\_\_\_ Work

\_\_\_\_\_ Moving \_\_\_\_\_ Lack of interest \_\_\_\_\_ Other (describe) \_\_\_\_\_

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7. Have you ever missed two consecutive weeks or longer? \_\_\_\_\_ Yes \_\_\_\_\_ No

8. Is this your first time attending college? \_\_\_\_\_ Yes \_\_\_\_\_ No

9. Is this your first time attending MVCC? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 \*If no, what year/semester did you last attend? \_\_\_\_\_
10. When you were attending your last school, what were your **most successful** classes?  
 \_\_\_\_\_  
 \_\_\_\_\_
11. When you were attending your last school, what were your **least successful** classes?  
 \_\_\_\_\_  
 \_\_\_\_\_
12. Check any of the following **campus resources** you think might be beneficial to you:  
 \_\_\_\_\_ Tutoring services \_\_\_\_\_ Counseling office  
 \_\_\_\_\_ Writing center \_\_\_\_\_ Career services  
 \_\_\_\_\_ Other (please list) \_\_\_\_\_
13. Check any of the following **off-campus** resources you are currently using:  
 \_\_\_\_\_ Relaxation therapy \_\_\_\_\_ Physical therapy  
 \_\_\_\_\_ Occupational therapy \_\_\_\_\_ Alcohol/drug rehabilitation  
 \_\_\_\_\_ Private counseling \_\_\_\_\_ Out-patient psychological services  
 \_\_\_\_\_ Department of Rehabilitation Services (which office) \_\_\_\_\_  
 \_\_\_\_\_ Other (please list) \_\_\_\_\_

### **Background Information – Goals**

1. What are you educational goals?  
 \_\_\_\_\_ Certificate \_\_\_\_\_ Bachelor's Degree  
 \_\_\_\_\_ Associate's Degree \_\_\_\_\_ Master's Degree  
 \_\_\_\_\_ Other (please explain) \_\_\_\_\_
2. What are your career goals? \_\_\_\_\_  
 \_\_\_\_\_
3. What would you like to major in? \_\_\_\_\_

### **Background Information – Family**

1. List the members of your immediate family (i.e., parents, brothers, sisters) and briefly discuss the dynamics (how well you get along) of your family: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Have any of your immediate family members experienced difficulties in school? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Is it easy for you to make friends? \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Disability Information**

1. Please check any conditions which apply to you:

\_\_\_\_\_ ADD/ADHD                      \_\_\_\_\_ Specific Learning Disability (LD)  
 \_\_\_\_\_ Autism/Asperger's        \_\_\_\_\_ Other health impaired (please explain): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Have you ever been diagnosed as having a disability? \_\_\_\_\_ Yes \_\_\_\_\_ No

If **no**, go on to question 2. If **yes**, in your own words, describe your disability below:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When was the diagnosis made? \_\_\_\_\_

Who made the diagnosis? \_\_\_\_\_

After the diagnosis what services were provided to you? \_\_\_\_\_  
 \_\_\_\_\_

How long did you use these services? (Check the answer that best describes the length of time): \_\_\_\_\_ 1-3 years    \_\_\_\_\_ 4-6 years    \_\_\_\_\_ 7-9 years    \_\_\_\_\_ over 9 years

3. Have you ever been placed in a special education or resource class? \_\_\_\_\_ Yes \_\_\_\_\_ No

If **yes**, what type of class(es) were you placed in? \_\_\_\_\_  
 \_\_\_\_\_

What grade were you in when you were placed in that class? \_\_\_\_\_

How long were you in the special education or resource class? \_\_\_\_\_

4. Describe your compensation strategies/methods (how you overcome your disability): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Background Information – Health**

1. Please check any conditions which apply to you:

Head Injury       Chronic ear infections       Asthma  
 Diabetes       Eye infections       Allergies  
 Seizures       Emotional/psychological       Other (please specify):  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Have you ever been hospitalized?       Yes       No

3. Has illness or injury ever interrupted your attendance in school?       Yes       No

4. Are you currently taking any medication?       Yes       No

If **yes**, what is the name of the medication(s)? \_\_\_\_\_  
 \_\_\_\_\_

What is the purpose of the medication(s)? \_\_\_\_\_  
 \_\_\_\_\_

5. Have you ever participated in individual or group counseling?       Yes       No

If **yes**, please describe further: \_\_\_\_\_  
 \_\_\_\_\_

6. Please indicate your current state of physical health by checking the answer below that fits you best:

Excellent     Good     Average     Poor     Not Sure

7. Please indicate your current state of mental health by checking the answer below that fits you best:

Excellent     Good     Average     Poor     Not Sure

8. When was your last vision exam? \_\_\_\_\_

Do you need to wear glasses?       Yes       No

9. When was your last hearing exam? \_\_\_\_\_

Do you suspect you may have a hearing problem?       Yes       No

**General Information**

1. Are you currently employed?       Yes       No

If **yes**, do you work on campus?       Yes       No

2. On the average, how many hours per week do you work? (Check the answer that best describes you)

1-10 Hours       11-20 Hours       21-30 Hours  
 31-40 Hours       40 Hours or more       Varies

4. How many credit hours are you currently enrolled in? \_\_\_\_\_
5. What courses are you taking this semester? (Please fill in the chart below)

| Course Name | Course Number | Day/Time of Class | Instructor |
|-------------|---------------|-------------------|------------|
|             |               |                   |            |
|             |               |                   |            |
|             |               |                   |            |
|             |               |                   |            |
|             |               |                   |            |
|             |               |                   |            |

6. Are you receiving any additional outside assistance or financial aid? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If **yes**, what kind? \_\_\_\_\_
7. What do you like to do during your free time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Please provide any other information that you feel is important for us to know below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Writing Sample** – Please write a few sentences on the following topic:

Why do you want to attend Moraine Valley Community College and what do you hope to gain from this experience?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**This concludes the Program Intake Information Questionnaire.**

**Please return this questionnaire to the Center for Disability Services, L150 before or at the time of your appointment.**

Adapted from, *Student Report Questionnaire* (2005) San Antonio, Texas: University of the Incarnate Word and from *Screening to Accommodation: Providing Services to Adults with Learning Disabilities* (1997) Boston: Association on Higher Education and Disability.