

Name: _____SSN or Student ID#: _____

Semester/Year: _____ Date: _____

WEST VALLEY COLLEGE
Disability and Educational Support Program
(DESP)
Intake/Interview Booklet

INTAKE INTERVIEW

Disability and Educational Support Program

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, in order to receive funds 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 _____ Home Phone _____

City _____ Zip _____

Can you be contacted at work? Yes No Work Phone _____

Gender _____ Date of Birth _____ Place of Birth _____

List name of person to notify in case of emergency during the weekdays:

Name _____ Relationship _____ Phone _____

Address _____ City _____ Zip _____

E-mail Address _____ Cell Phone _____

REFERRAL INFORMATION

1. Who referred you to our program? _____ (Name) _____ (Agency)

2. Why were you referred? _____

3. In what academic areas have you experienced difficulty? (Check all that apply.)

_____ Reading

_____ Spelling

_____ Math

_____ Writing

_____ Taking tests

_____ Study skills

_____ Taking notes

_____ Understanding lectures

_____ Comprehending concepts

_____ Remembering information

_____ Completing assignments on time

_____ Organizing written work

_____ Self-confidence in school

_____ Motivation

_____ Time management

4. Describe your academic difficulties _____

5. 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. What is your Dept. of Rehab. Status? Just Applied Current Closed
 - c. Rehabilitation counselors name _____ Phone _____
 - d. What is your rehabilitation plan? _____

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

_____ DSP&S	_____ EOPS	_____ Cal Works	_____ Financial Aid
_____ SSI	_____ SSDI	_____ San Andreas Regional Center	
_____ None	_____ Other Services	_____	_____

DEVELOPMENTAL HISTORY

7. Were there any medical or developmental problems before or after your birth or during the birth process? Yes No

If yes, explain _____

8. 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 _____

9. Do you feel you grew up in a stimulating environment in terms of each of the following:

- a. frequent exposure to spoken language Yes No
- b. availability of books, magazines, or other print materials Yes No
- c. enrichment experiences (e.g., museums, libraries, etc.) Yes No

Please explain _____

FAMILY HISTORY

10. Does anyone in your family have a learning problem? Yes No

- If yes, describe _____

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

- If yes, describe _____

12. Describe any family or personal issues that you feel have affected your learning in the past. _____

13. Describe any current family or personal issues that are impacting your education at this time.

WORK HISTORY

14. Are you currently employed Yes No

If yes, please describe current employment:

- a. Where? _____
- b. Job Duties? _____
- c. Number of hours per week? _____ Job Title _____
- d. What is your weekly work schedule? _____
- e. How long have you had this job? _____ Years _____ Months _____ Weeks

15. Describe any previous jobs, length of employment, and job duties. _____

HEALTH INFORMATION

PHYSICIAN'S NAME: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

Disability (list all physical conditions – such as: CP, CVA, heart by-pass, etc): _____

Resulting limitations: _____

Allergic to the following medication(s) _____

16. Do you have vision problems Yes No

If yes, describe: _____

17. Do you wear glasses or contact lenses? Yes No

18. Have you had an eye exam within the last two years? Yes No

If yes, when? _____

19. Do you have problems with hearing? Yes No

If yes, describe: _____

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

21. Do you wear a hearing aid? Yes No

22. Have you had a hearing exam within the last five years? Yes No

If yes, when? _____

23. 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 _____

24. Have you ever been on a long-term program of medication? Yes No

• If yes, describe _____

25. Do you have allergies or asthma? Yes No

If yes, please answer the following questions:

a. Describe: _____

b. How do the allergies, asthma, and/or medications influence your class work? _____

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

a. attention? Yes No

b. concentration? Yes No

c. hyperactivity? Yes No

• If yes, describe difficulties during each of the following:

a. study time _____

b. lecture _____

c. tests _____

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

• If yes, when and by whom? _____

What were the results? _____

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

• If yes, at what age? _____ Were you hospitalized? Yes No

Please explain _____

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

• If yes, for how long? _____

Please explain _____

30. Have you ever had seizures? Yes No

• If yes, specify when and describe: _____

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

• If yes, please answer the following questions:

a. at what age? _____

b. for what reason? _____

32. Have you ever had any serious injuries or illness? Yes No
- If yes, specify when and please describe their impact on your education: _____
-
33. Do you have a history of mental health problems? Yes No
- If yes, please answer the following questions:
 - a. Were you ever hospitalized for mental health problems? Yes No
 - b. Have you been treated as an outpatient? Yes No
 - c. Have you participated in mental health counseling? Yes No
34. Do you have a history of substance abuse? Yes No
- If yes, please answer the following questions:
 - a. Were you ever hospitalized for substance abuse? Yes No
 - b. Have you been treated as an outpatient? Yes No
 - c. Have you participated in counseling for substance abuse? Yes No
 - d. For how long have you maintained sobriety? _____

EDUCATIONAL INFORMATION

35. As far as you can recall, when did you first start having problems in school?
- _____
36. Why do you think you have had problems in school? (Check all that apply.)
- | | | |
|---|---|--|
| <input type="checkbox"/> Specific learning disability | <input type="checkbox"/> Tasks too difficult | <input type="checkbox"/> Bad luck |
| <input type="checkbox"/> Home environment | <input type="checkbox"/> Lack of interest in school | <input type="checkbox"/> Limited ability |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Lack of opportunity | <input type="checkbox"/> Poor attendance |
| <input type="checkbox"/> Economic disadvantage | <input type="checkbox"/> Other (specify): _____ | |
37. Did you frequently change schools in elementary or secondary school? Yes No
- If yes, explain: _____
-
38. Did you ever stay back or repeat a grade in school? Yes No
- If yes, what grade(s) and why? _____

39. Were you ever tested for eligibility in special education prior to college? Yes No
- If yes, when and why? _____
40. 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 Resource Program Remedial Class
- Speech and Language services Gifted Other _____
- If you were in special education or remedial classes, in what high school classes were you mainstreamed? _____
41. What other school-related activities or issues influenced your achievement (e.g., sports, clubs, etc.)?
- _____
- _____
42. Did you drop out of school between kindergarten and 12th grade? Yes No
- If yes, please answer the following questions:
 - in what grade(s)? _____
 - for what reasons? _____
 - did you complete a GED? If yes, when? _____
43. Are you a high school graduate? Yes No
- If yes, a. list name and location of high school: _____
 - b. date of graduation: _____
44. Have you attended any other college or university? Yes No
- If yes, where? _____
45. For how many semesters/quarters have you attended college? _____
46. How many units have you earned? _____
47. In how many units (hours) are you currently enrolled? _____ Units (hours)
48. Are you required to take a certain number of units? Yes No
- If yes, how many units and why? _____
49. Are you on academic probation or dismissal? Yes No
- If yes, why? _____

50. Are you on progress probation or dismissal? Yes No

• If yes, why? _____

51. Describe any problems you are experiencing with your current classes. How much time do you spend each week (including Saturday and Sunday) studying and preparing for each of these classes?

Class	Describe Difficulties	Weekly Study Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

53. What college support services have you used? List the college(s), the service you received and the length of time used. _____

54. In what type(s) of classes have you done well? _____

55. What are your goals for attending college? _____

College Major _____ College Counselor _____

56. List the highest level English, math, reading, and study skills courses you have completed (including high school if appropriate.)

Class	Level (basic skills, advanced, grade level, algebra, etc)	Grade Received	Date Completed
English: _____	_____	_____	_____
Math: _____	_____	_____	_____
Reading: _____	_____	_____	_____
Study Skills: _____	_____	_____	_____

CULTURAL AND LINGUISTIC INFORMATION

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

57. Where were you born? _____

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? (includes exposure to schools, television, libraries, etc.) Yes No

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

• If no, please answer the following questions:

a. What other language(s) do you speak? _____

b. What other language(s) do you read? _____

c. What other language(s) do you write? _____

d. What language did you learn first? _____

e. What is your primary language? _____

f. In which language do you feel you communicate best? _____