

Student Questionnaire

SRJC Student ID #	Today's Date	
Student's Last Name	First Name	M. I.

Medical History

Disability/Condition	Onset Age	Limitations (How it affects you) Please respond in reference to the classroom setting.

Name of Medication	Dosage	Side Effects

Physician	Telephone (please include area code)
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Street Address		
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City	State	Zip
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Psychiatrist/Psychologist	Telephone (please include area code)
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Street Address		
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City	State	Zip
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Other Currently Seen Professional	Telephone (please include area code)
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Street Address		
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City	State	Zip
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Education History/Goal

Yes No Did you obtain a high school diploma, certificate of completion or GED?

Yes No Have you attended college? If yes, where and when:

Goal: Associate Degree Bachelor Degree Job Skills Certificate Other:

Veteran Information

Yes No Are you a veteran? Dates of service:

Yes No Was your disability acquired through your military service?

Health Information

Yes No Have you ever had a seizure? If yes, what type: Date of last seizure:

Yes No Do you use a wheelchair?

Yes No Are you able to find your way around campus?

Yes No Do you require a personal attendant? If yes, for which of the following:
 Eating Restroom Transfer Dressing

SRJC doesn't provide personal attendants.

Yes No Are you able to provide your own personal attendant?

Brain Injury

Have you ever had a brain injury? If **yes**, please complete the following section:

Date of Injury: What type of brain injury did you have (check box below)?

Stroke Head Trauma Tumor Other:

Yes No Were you hospitalized? If yes, for how long?

Yes No Are you currently receiving therapy? Check all that apply:
 Physical Occupational Speech Psychological

Yes No Do you have difficulty seeing?

Yes No Do you ever feel dizzy?

Yes No Do you have difficulty hearing?

Yes No Do you have difficulty finding your way around?



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