

ADAAA-SWOSU Program Welcome Information Questionnaire

To be completed by the student.

Bring with you to Dean of Students Office, STF 214, each semester prior to your ADA welcome interview. Accommodations will follow that meeting. Call 580-774-3767 to schedule your appointment.

Personal Information

Name: _____
Student ID: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Alternate Phone: _____
Email Address: _____

Directions: The answers you provide on this questionnaire will be valuable in determining how we may best assist you. Please answer all questions to the best of your ability. Information gathered on the questionnaire is considered **private** and will not be shared with any one else without written permission.

Background Information - Learning

- 1) Primary language currently spoken in your home: _____
- 2) If **not** English – How old were you when you began learning English? _____
- 3) What kind of learner are you? (Place a check mark in front of the answer that best describes you):
 I learn by what I see.
 I learn by what I hear.
 I learn hands-on.
 I learn by combining two or more of the ways listed above.
 I learn in a way not listed above. Please describe how you learn:

- 4) How do you prefer to **receive** information?
 Demonstration Video/Film/TV Lecture
 Computer/Online Reading Directed Practice
 Audio Recording Group Discussion
 Other: (Please be Specific) _____

- 5) How do you prefer to **express** (show) what you have learned?
 Demonstration Video/Film/TV Speech
 Computer/Online Reading Written Product
 Audio Recording Group Discussion Taking a Test
 Other: (Please be Specific) _____

- 6) What study techniques do you currently use? (Check all that apply)
- | | | |
|--|---|---|
| <input type="checkbox"/> Quiet Setting | <input type="checkbox"/> Paraphrasing | <input type="checkbox"/> Regular Study Schedule |
| <input type="checkbox"/> Mnemonics | <input type="checkbox"/> Study Group(s) | <input type="checkbox"/> Long-Term Planning |
| <input type="checkbox"/> Tutoring | <input type="checkbox"/> Outlining | <input type="checkbox"/> Timely Review of Notes |
| <input type="checkbox"/> Daily Planner | <input type="checkbox"/> Flashcards | <input type="checkbox"/> ID of Key Points |
| <input type="checkbox"/> Highlighting | <input type="checkbox"/> Marginal Notes | <input type="checkbox"/> Assignment Notebooks |
| <input type="checkbox"/> Affirmations | <input type="checkbox"/> Cornell Note Taking System | |
| <input type="checkbox"/> Other: (Please be specific) _____ | | |

- 7) Which of the items below, best describes your concentration and attention in class and/or when studying or taking a test? (Check all that apply)
- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Fidgety | <input type="checkbox"/> Distractible |
| <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Difficulty Reading | <input type="checkbox"/> Test Anxiety |
| <input type="checkbox"/> Other: (please be specific) _____ | | |

- 8) Of the following, check those areas with which you have difficulty. (Check all that apply)
- | | |
|---|--|
| <input type="checkbox"/> Understanding class lectures | <input type="checkbox"/> Procrastinating |
| <input type="checkbox"/> Memorizing facts and/or figures | <input type="checkbox"/> Concentrating when studying |
| <input type="checkbox"/> Concentrating during a class lecture | <input type="checkbox"/> Being prepared for class and/or tests |
| <input type="checkbox"/> Remembering telephone numbers | <input type="checkbox"/> Remembering names of people/places |
| <input type="checkbox"/> Reversing letters or numbers | <input type="checkbox"/> Sequencing steps of a task |
| <input type="checkbox"/> Reading/following directions or maps | <input type="checkbox"/> Understanding what is read |
| <input type="checkbox"/> Keeping up with assignments | <input type="checkbox"/> Meeting new people |
| <input type="checkbox"/> Frequent absences | <input type="checkbox"/> Talking to instructors |
| <input type="checkbox"/> Managing time | <input type="checkbox"/> Beginning assignments |
| <input type="checkbox"/> Completing assignments | <input type="checkbox"/> Organizing written papers |
| <input type="checkbox"/> Keeping appointments | <input type="checkbox"/> Writing speed |
| <input type="checkbox"/> Writing legibly | <input type="checkbox"/> Oral expression of thoughts |
| <input type="checkbox"/> Learning formulas | <input type="checkbox"/> Processing information slowly |
| <input type="checkbox"/> Family commitments | <input type="checkbox"/> Handing in incomplete assignments |
| <input type="checkbox"/> Not finishing tests | <input type="checkbox"/> Over-extended with activities |
| <input type="checkbox"/> Over-extended with work | <input type="checkbox"/> Cramming for tests |
| <input type="checkbox"/> Other: (please specify): _____ | |

- 9) Approximately how much time do you spend studying **each day**? _____

10) Of the test taking behaviors listed below – which apply to you? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> I understand test directions | <input type="checkbox"/> I survey the test before beginning |
| <input type="checkbox"/> I outline essay question | <input type="checkbox"/> I manage my time while taking tests |
| <input type="checkbox"/> I restate questions | <input type="checkbox"/> I skip difficult questions |
| <input type="checkbox"/> I eliminate incorrect answers | <input type="checkbox"/> I use mnemonics |

11) What are your strengths? (Please list below):

12) What are your areas of concern? (Please list below):

13) Place an “**A**” in front of any of the following resources you are currently using and a “**B**” in front of those you have used in the past:

- | | |
|---|---|
| <input type="checkbox"/> Tutoring services | <input type="checkbox"/> Counseling services |
| <input type="checkbox"/> Writing center | <input type="checkbox"/> Career/Vocational services |
| <input type="checkbox"/> Relaxation therapy | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> Alcohol/drug rehab | <input type="checkbox"/> Out-patient psychological services |
| <input type="checkbox"/> Other (please list): _____ | |

Background Information – Miscellaneous

1) Have you ever been diagnosed as having a disability? Yes No
If **yes**, in your own words, describe your disability below:

When was the diagnosis made?

Who made the diagnosis?

After the diagnosis was made, what services/accommodations did you receive?

How long have you used these services/accommodations? (Check the answer below that best describes the length of time):

Under a year 1-4 years 4-6 years 7-9 years Over 9 years