Subject Screening Questionnaire

PLEASE RETURN THIS QUESTIONNAIRE TO MARIA MODY (RM 1102)

INFORMATION PROVIDED IN THIS QUESTIONNAIRE WILL REMAIN CONFIDENTIAL. INFORMATION ABOUT YOU WILL BE AVAILABLE ONLY TO THE RESEARCHER IN CHARGE OF THIS PROJECT.

1. Today's Date: ________________

2. Name: ____
(first) (middle) (last)

3a. Date of Birth: ________________________ 3b. Sex: Male Female

4. Address: ____
(Street) (Apt.) (City) (State) (Zip)

5. Home Telephone Number: ( ) __________ 6. Email Address: _________

7. Race:
(1) White, not of Hispanic Origin
(2) Black, not of Hispanic Origin
(3) Hispanic
(4) American Indian or Alaskan Native
(5) Asian or Pacific Islander
(6) Other (please specify) __________

8. Education: Post-graduate____Graduate_____Undergraduate____High School ____

9. Handedness:
Write: R / L / A
Throw Ball: R / L / A
Brush Teeth: R / L / A
Swing Bat: R / L / A
Hammer Nail: R / L / A

10. What was the first language you learned? ___________________________

11. What language do you speak most of the time? ______________________

12a. Do you have a problem in any of the following areas: speech ____ language ____ reading ____ attention ____

12b. Have you ever seen a specialist for speech, hearing, language, reading or attention related problems? Yes / No

If yes, when ____________ and for how long? ___________________

What was the nature of the problem? ____________________________

13. Were you ever in any remedial reading classes? Yes / No

14. Do you currently have any hearing problems? Yes / No

15. Do you wear a hearing aid? Yes / No

16. Vision Status:
(1) Normal without glasses/contacts
(2) Corrected by glasses/contacts to normal
(3) Vision impairment with glasses/contacts – Please specify: _______________

17. Have you ever had corrective surgery for your eyesight? Yes / No

18. List any major hospitalizations

19. Are you currently taking any medication? Yes / No

If yes, what is the medication for? ________________________________

20. Birth Status:
(1) Premature
(2) Full Term

21. Any birth complications when you were delivered? Yes / No
If yes, what? ____

22. Do you have any neurological conditions (e.g. epilepsy)? Yes / No

23. Do you have a history of psychological problems (e.g. depression) Yes / No

24. Indicate times during which you are available to come in for testing:

Times:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9 AM-noon							
Noon-3 PM							
3 PM-6 PM							
6 PM-9 PM							
9 PM-midnight							

Thank you! We will try our best to accommodate your scheduling preferences.