

Your Name _____

Date _____

INITIAL LEARNING ASSESSMENT

During your visit with our organization you will be presented with information that may be new to you. To aid in providing the best care possible please answer the following questions. Thank You

How do you like to learn new things? Please check all that apply

	Reading		Pictures/Diagrams
	Discussion		Hands On/Demonstration
			Self-study
			Other

Factors that can affect learning:	Yes	NO	Comments
Do you speak English in your home?			If no what language do you speak? Name of interpreter:
Can you read English?			
Can you write English?			
Do you hear well?			If no, do you utilize a hearing device? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you see well?			If no, do you utilize glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any cultural or religious practice/beliefs that may affect your care or treatment?			If Yes, explain

Other comments _____