

# LAMPREY HEALTH CARE

## Learning Assessment Questionnaire

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Please check all that apply.

### Question #1 - When we share information with you, what is your preference for learning?

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Written-pamphlets, booklets, handouts | <input type="checkbox"/> One-on-One Discussions |                                      |
| <input type="checkbox"/> Hands On Practice & Demonstration     | <input type="checkbox"/> Videos                 | <input type="checkbox"/> Audio Tapes |
| <input type="checkbox"/> Verbal explanations                   | <input type="checkbox"/> Class                  | <input type="checkbox"/> Other       |

#### Additional Comments:

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### Question # 2 - Who else would you like to include in the education?

- |                                  |   |                                 |
|----------------------------------|---|---------------------------------|
| <input type="checkbox"/> Sibling | <input type="checkbox"/> Spouse/partner | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Child   | <input type="checkbox"/> No One         | <input type="checkbox"/> Other  |

#### Additional Comments:

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### Question # 3 - What things might affect you or your family's ability to learn?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> None                          | <input type="checkbox"/> Learning problems  | <input type="checkbox"/> Emotional barriers |
| <input type="checkbox"/> Language                      | <input type="checkbox"/> Physical problems  | <input type="checkbox"/> Financial issues   |
| <input type="checkbox"/> Reading ability (literacy)    | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Disinterest        |
| <input type="checkbox"/> Religious or cultural beliefs | <input type="checkbox"/> Vision impairment  | <input type="checkbox"/> Other              |

#### Additional Comments:

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