

**NIAGARA HEALTH CENTER**  
**SPINE PAIN DIAGNOSTICS ASSOCIATES**  
*A Division of Wisconsin Michigan Physicians*

**INITIAL LEARNING ASSESSMENT**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_ Physician:  Singh  Piryani  Liao  
MR#: \_\_\_\_\_  Jollu  Santino

**During your visit with our organization you will be presented with information that may be new to you. To aid us in providing this information to you in a manner that allows for optimal understanding, please answer the following questions.**

1. How do you like to learn new things? Please check all that apply.  
 Verbal  Written  Visual
2. Do you speak English in your home?  Yes  No  
If no, what language do you speak? \_\_\_\_\_  
Name of Interpreter: \_\_\_\_\_
3. Can you read English?  Yes  No
4. Can you write English?  Yes  No
5. Can you hear well?  Yes  No  
If no, do you use a hearing device?  Yes  No
6. Do you need to receive information through sign language?  Yes  No
7. Do you see well?  Yes  No  
If no, do you wear glasses or contacts?  Yes  No
8. Do you forget things easily?  Yes  No
9. Do you feel your level of pain interferes with learning?  Yes  No
10. Do you feel the need to have a family member or someone present during education?  Yes  No
11. Do you have any cultural or religious practices/beliefs that may affect our care or treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Staff Use Only***

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**STAFF ASSESSMENT**

**1. Barriers to Patient Teaching/Learning:**

- None Identified
- Reading Barrier
- Hearing Impairment
- Visual Impairment
- Cognitive Impairment
- Pain Level
- Cultural
- Lack of Motivation

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**INITIAL LEARNING ASSESSMENT**

Emotional

Other: \_\_\_\_\_

2. Patient / Family readiness to Learn:

Accurately explains reason for visit and relates medical history?  Yes  No

Verbalizes readiness and willingness to learn about plan of care?  Yes  No

3. Preferred Method of Learning:

Verbal       Written       Demonstration

4. Patient / Family verbalized understanding of information provided?  Yes  No

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

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Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_