** Office of Accessibility & Accommodations**

Eastern Illinois University

600 Lincoln Avenue

Charleston IL 61920-3099

217-581-6583 (Voice/TTY)

217-581-7208 (Fax)

**Documentation of Psychological Disorder**

# Student Information

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| Student Name: |

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| Student EIU E Number: |

Student has recently requested accommodations from Office of Accessibility & Accommodations on the basis of a psychological disability. Your name has been provided as the diagnosing professional, you are

requested to complete **all** sections of this form.

Please return the completed form to Office of Accessibility & Accommodations at the above address or by email to [accommodations@eiu.edu](mailto:accommodations@eiu.edu). Thank you for your prompt reply so we can begin providing services as

soon as possible.

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| Diagnosis Code DSM-V | Diagnosis DSM-V |
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| Are there any pending diagnoses? |
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| Date of diagnoses: |
| Date of last contact: |
| Date of first contact with client: |
| Frequency of contact: |

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| --- |
| Consultation with other medical or mental health professional, name and date: |
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In addition to the DSM diagnostic criteria, what other information did you collect to arrive at your diagnosis?

☐ Behavioral observations

☐ Developmental history

☐ Rating scales (e.g., Beck Depression Scale, etc.)

☐ Medical history

☐ Structured or unstructured clinical interview with the student

☐ Interviews with others (parents, teachers, spouse or significant others)

☐ Neuropsychological, psycho educational testing, etc.

Dates of testing \_\_\_\_\_\_\_\_\_\_\_

# History

Is the student currently receiving psychotherapy?

* Yes
* No

If yes, how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the student currently taking medications?

* Yes
* No
* NA – not prescribing physician

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| If yes, describe the impact of the medication on the student’s ability to participate in the educational process (whether the impact is negative or mitigating). |
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Has the student been hospitalized or received in-patient care for this/these disorder(s) in the past?

* Yes
* No

If yes, what are the dates of these treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there evidence of previous treatment by a health care professional?

* Yes
* No

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| If yes, please explain: |
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# Symptom Assessment

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| Describe how the student is substantially limited by the symptoms: |
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Please rate the frequency/duration and severity of the relevant symptoms as related to the disability.

**Frequency:** How frequently do limitations occur?

**0**=never, **1**=rarely, **2**=intermittently, **3**=frequently

**Duration:** How long has the student experienced these limitations?

**1**=more than 1 year, **2**=months, **3**=recent acute onset

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| --- | --- | --- | --- | --- | --- | --- |
| **Mental Health Symptoms** | **Frequency Scale 0-3 (see scale above)** | **Duration Scale 1-3 (see scale above)** | **Severity** | | | **Comments** |
| **Mild** | **Moderate** | **Severe** |
| Compulsive Behaviors |  |  |  |  |  |  |
| Impulsive Behaviors |  |  |  |  |  |  |
| Obsessive Thoughts |  |  |  |  |  |  |
| Depressed Mood |  |  |  |  |  |  |
| Disordered Eating |  |  |  |  |  |  |
| Fatigue/Loss of Energy |  |  |  |  |  |  |
| Hypomania |  |  |  |  |  |  |
| Racing Thoughts |  |  |  |  |  |  |
| Self-Injurious Behavior |  |  |  |  |  |  |
| Suicidal Ideation |  |  |  |  |  |  |
| Suicide Attempts |  |  |  |  |  |  |
| Panic Attacks |  |  |  |  |  |  |
| Phobia (specify): |  |  |  |  |  |  |
| Anxious Mood |  |  |  |  |  |  |
| Unable to Leave House |  |  |  |  |  |  |
| Delusions |  |  |  |  |  |  |
| Hallucinations |  |  |  |  |  |  |
| Other, please specify: |  |  |  |  |  |  |

Please rate the frequency/duration and severity of the relevant symptoms as related to the disability.

**Frequency:** How frequently do limitations occur?

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| **Physiological Symptoms** | **Frequency**  **Scale 0-3**  **(see scale above)** | **Duration**  **Scale 1-3**  **(see scale above)** |  | **Severity** |  | Comments |
| **Mild** | **Moderate** | **Severe** |
| Dizziness |  |  |  |  |  |  |
| Fainting |  |  |  |  |  |  |
| Racing Heart |  |  |  |  |  |  |
| Migraines/Headaches |  |  |  |  |  |  |
| Nausea |  |  |  |  |  |  |
| G.I. Distress |  |  |  |  |  |  |
| Shortness of Breath |  |  |  |  |  |  |
| Chest Pain |  |  |  |  |  |  |
| Other, please specify: |  |  |  |  |  |  |
| Other, please specify |  |  |  |  |  |  |

Please rate the frequency/duration and severity of the relevant symptoms as related to the disability.

**Frequency:** How frequently do limitations occur?

**0**=never, **1**=rarely, **2**=intermittently, **3**=frequently

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| **Major Life Activity** | **Frequency**  **Scale 0-3**  **(see scale above)** | **Duration**  **Scale 1-3**  **(see scale above)** | **Severity** | |  | **Comments** |
| **Mild** | **Moderate** | **Severe** |
| Initiating Activities |  |  |  |  |  |  |
| Concentration |  |  |  |  |  |  |
| Following Directions |  |  |  |  |  |  |
| Memorization |  |  |  |  |  |  |
| Persistence |  |  |  |  |  |  |
| Processing Speed |  |  |  |  |  |  |
| Organizational Skills |  |  |  |  |  |  |
| Sustained Reading |  |  |  |  |  |  |
| Sustained Writing |  |  |  |  |  |  |
| Problem Solving |  |  |  |  |  |  |
| Listening |  |  |  |  |  |  |
| Sitting |  |  |  |  |  |  |
| Speaking |  |  |  |  |  |  |
| Interacting with Others |  |  |  |  |  |  |
| Sleeping |  |  |  |  |  |  |
| Self-Care |  |  |  |  |  |  |
| Other, please specify: |  |  |  |  |  |  |

# Impact in Post-Secondary Setting

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| Provide comments on daily life impairment experienced by student in a post-secondary setting: |
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# Anticipated Progress and Prognosis

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| Progress and anticipated prognosis (if relevant, provide information on the cyclical nature or known environmental triggers): |
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# Additional Comments

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# Certifying Licensed Mental Health Professional

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| Clinician Name: |

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| Clinician Signature: |

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| Medical Specialty: |

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| License/Certification Number |

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| Address: |

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| Phone: |

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| Email: |

|  |
| --- |
| Date: |

# EIU Contact Information

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600 Lincoln Ave

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