** 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. 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?

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

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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

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

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

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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: |

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| --- |
| Date:  |

# EIU Contact Information

Office of Accessibility & Accommodations

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600 Lincoln Ave

Charleston IL 61920

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Fax 217-581-7208

Email: accommodations@eiu.edu