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

Student Name:

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.

Diagnosis Code DSM-V	Diagnosis DSM-V

Are there any pending diagnoses?

Date of diagnoses:
Date of last contact:
Date of first contact with client:
Frequency of contact:

Consultation with other medical or mental health professional, name and date:

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

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).

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

If yes, please explain:

Symptom Assessment

Describe how the student is substantially limited by the symptoms:

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

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

Duration: How long has the student experienced these limitations?

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

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

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

Provide comments on daily life impairment experienced by student in a post-secondary setting:

Anticipated Progress and Prognosis

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

Additional Comments

Certifying Licensed Mental Health Professional

Clinician Name:

Clinician Signature:

Medical Specialty:

License/Certification Number

Address:

Phone:

Email:

Date:

EIU Contact Information

Office of Accessibility & Accommodations
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