**Mental Health Disability Assessment Form**

This form is to be completed by a certified mental health professional for a University of Chicago student.

Student Disability Services (SDS) provides services and accommodations to persons with disabilities to ensure **equal access and opportunity to educational programs and activities**. Current and comprehensive disability documentation is required to verify that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as amended in 2008. These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for disability services is based, in part, on documentation that clearly demonstrates that the student has one or more functional limitations. Students must meet with an SDS staff person and clearly articulate the need for accommodations for equal access with timely notice of all requests.

The information from this completed form will be used to determine a student’s eligibility to receive access accommodations. Disability documentation must include the following elements.

1. Credentials of the evaluator
2. Current statement of diagnosis
3. Comprehensive evaluation, including:
	1. Description of diagnostic methodology
	2. Relevant history
	3. Assessment of functional limitations
	4. Treatment / medication and prognosis
	5. Accommodation recommendations based on addressing areas of impairment.

Please review our detailed documentation guidelines for mental health disabilities on our website
<https://disabilities.uchicago.edu/students/psychological-disability-accommodations/>

**Student Consent**

I, Click or tap here to enter text., authorize my health-care provider above to release to Student Disability Services the medical information requested on this form for the purpose of determining appropriate accommodation for my disability while a student at the University of Chicago.

Signature of student: Type your signature here. Date: Click or tap to enter a date.

If signed by person other than patient, state relationship and authority to do so. Click or tap here to enter text.

Expiration Date: Click or tap to enter a date.

**Student Information**

Student Name: Click or tap here to enter text.

**Certifier Information**

Clinician Name: Click or tap here to enter text.

Clinician Signature: Type your signature here.

Medical Specialty: Click or tap here to enter text.

License/Certification #: Click or tap here to enter text.

Clinician Email Address: Click or tap here to enter text.

Address:

Click or tap here to enter text.

Phone: Click or tap here to enter text.

**Please complete the following:** Today’s Date: Click or tap to enter a date.

**Diagnosis**

Name of the DSM-5 diagnosis (or ICD-10 code):

Click or tap here to enter text.

Are there any pending diagnoses?

Click or tap here to enter text.

Date of diagnosis: Click or tap to enter a date.

Date of first contact with student: Click or tap to enter a date.

Date of last contact: Click or tap to enter a date.

Frequency of contact: Click or tap here to enter text.

Consultation with other medical or mental health professional:
Name: Click or tap here to enter text. Date: Click or tap to enter a 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: Click or tap here to enter text.)

What methods or tools were utilized to assess functional limitation? Please list (or attach under separate cover?

Click or tap here to enter text.

**History**

Is the student currently receiving psychotherapy? [ ]  Yes [ ]  No

 If yes, how often? Click or tap here to enter text.

Is the student current taking medications? [ ]  Yes [ ]  No [ ]  N/A – 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):

Click or tap here to enter text.

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? Click or tap here to enter text.

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

 [ ]  Yes [ ]  No

 If yes, please explain: Click or tap here to enter text.

Describe how the student is substantially limited by the symptoms (refer to the next pages for a list):

Click or tap here to enter text.

**Symptom Assessment List**

Please rate the frequency/duration and severity (using “x”) 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)** | **DurationScale 1-3 (see scale above)** | **Severity** |
|  |  |  | **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 |   |   |[ ] [ ] [ ]
| Panic Attacks |   |   |[ ] [ ] [ ]
| Phobia - specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   |   |[ ] [ ] [ ]
| Anxious Mood |   |   |[ ] [ ] [ ]
| Unable to Leave Residence |   |   |[ ] [ ] [ ]
| Delusions |   |   |[ ] [ ] [ ]
| Hallucinations |   |   |[ ] [ ] [ ]
| Other, please specify:   |   |   |[ ] [ ] [ ]
| Other, please specify:   |   |   |[ ] [ ] [ ]
| Click or tap here to comment on symptoms added above |

**Symptom Assessment List (continued)**

Please rate the frequency/duration and severity (using “x”) 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)** | **DurationScale 1-3 (see scale above)** | **Severity** |
|  |  |  | **Mild** | **Moderate** | **Severe** |
| Dizziness |   |   |[ ] [ ] [ ]
| Fainting |   |   |[ ] [ ] [ ]
| Racing Heart |   |   |[ ] [ ] [ ]
| Migraines/Headaches |   |   |[ ] [ ] [ ]
| Nausea |   |   |[ ] [ ] [ ]
| G.I. Distress |   |   |[ ] [ ] [ ]
| Shortness of Breath |   |   |[ ] [ ] [ ]
| Chest Pain  |   |   |[ ] [ ] [ ]
| Fatigue  |   |   |[ ] [ ] [ ]
| Light Sensitivity |   |   |[ ] [ ] [ ]
| Other, please specify:   |   |   |[ ] [ ] [ ]
| Other, please specify:   |   |   |[ ] [ ] [ ]
| Click or tap here to comment on symptoms added above.  |

**Functional Impact Assessment: Impact in Post-Secondary Setting**

Please rate the frequency/duration and severity (using “x”) of the condition’s impact on **relevant** major daily activities to the best of your knowledge. (For comparison purposes, please use same age peers in a postsecondary setting.)

**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)** | **DurationScale 1-3 (see scale above)** | **Severity** |
|  |  |  | **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 |   |   |[ ] [ ] [ ]

|  |
| --- |
| Click or tap here to comment on symptoms added above. |

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

Click or tap here to enter text.

**Anticipated Progress and Prognosis**

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

Click or tap here to enter text.

**Additional Comments and Recommended Accommodations**

(Accommodation recommendations must be based on a substantially limiting mental/physical impairment)

Click or tap here to enter text.