METHODIST UNIVERSITY

ACCESSIBILITY & DISABILITY SERVICES

# Mental Health Disability Assessment Form

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

Accessibility & Disability Services provides services and accommodations to persons with disabilities to ensure **equal access and opportunity to educational programs and activities. Documentation can aid us in the process** of determining if 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. Understanding of the functional limitations of the condition can help us determine appropriate accommodations for the student.

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

A. Credentials of the evaluator
B. Current statement of diagnosis
C. Comprehensive evaluation, including:
    **a.** Description of diagnostic methodology
    **b.** Relevant history
    **c.** Assessment of functional limitations
    **d.** Treatment / medication and prognosis
    **e.** Accommodation recommendations

For more information, review the documentation guidelines on our website: https://www.methodist.edu/academics/one-stop/accessibility/documentation/

I, _____, authorize my provider above to release to Student Disability Services the information requested on this form for the purpose of determining appropriate accommodation for my disability while a student at Methodist University.

Signature: _____ Date: _____

If signed by person other than patient, state relationship and authority to do so.

Relationship: _____ Legal Authority: _____

**Please complete the following:** Today's Date: _____

## Student Information

Student Name: _____ Student ID _____

## Diagnosis

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

Are there any pending diagnoses?

Date of diagnosis: _____ Date of first contact with client: _____

Date of last contact: _____ Frequency of contact: _____

Consultation with other medical or mental health professional:

Name: _____ 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: _____)

## Diagnosis (continued)

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

## History

Is the student currently receiving psychotherapy?

☐ Yes ☐ No

If yes, how often?

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):

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 (see next two pages for list):

## Symptom Assessment (continued)

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: | | | ☐ | ☐ | ☐ | |

## Symptom Assessment (continued)

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 | | | ☐ | ☐ | ☐ | |

## Functional Impact Assessment

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: | | | ☐ | ☐ | ☐ | |
| 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

## Certifier Information

Clinician Name:

Clinician Signature:

Medical Specialty:

License/Certification #:

Address:

Phone:

Email: Date

## Office Information

To return form or ask questions:

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