IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Student Accessibility Services
Dean of Students Office
1060 Hixson Lied Student Success Center
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Mental Health Assessment Form

Student Accessibility Services provides academic support and accommodations for students with disabilities. Students are required to provide documentation that verifies 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 Amendments Act (2008). These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly demonstrates a student has one or more functional limitations in an academic setting, and that one or more accommodations is needed to achieve equal access.

A client of yours has requested accommodations related to a reported disability. As this client's treating clinician/specialist, you are asked to provide the following information to allow the university to consider this client's service request(s).

Please complete the following:

1. Student Information:

Client Name:	
Preferred Name:	
Date of Birth (mm/dd/yyyy):	

2. Diagnosis: What is the DSM or ICD Diagnosis?

Are there any diagnoses that need to be ruled out?	

3. What 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. Date(s) of testing:

4. Date of diagnosis:

5. Date of first contact with client:

6. Date of most recent contact with client:

7. Number of appointments in the last 6 months:

8. Has this student been hospitalized or received in-patient care for their disorder in the past?

☐ Yes ☐ No

9. If yes, what has been the frequency and typical duration of these treatments?

10. Is the student currently receiving psychotherapy?

☐ Yes ☐ No

11. Is the student currently utilizing medication?

☐ Yes ☐ No

12. If yes, does the student currently experience any side effects or significant limitation as a result of the medication:

13. FUNCTIONAL IMPACT ASSESSMENT (REQUIRED)

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

Major Life Activity	**Frequency/Duration 0-4 Scale** 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic	**Severity**			
		Unknown/ N/A	**Mild**	**Moderate**	**Severe**
Initiating Activities					
Concentration					
Following Directions					
Eating					
Going to Class					
Impulse Control					
Memorization					
Motivation					
Persistence					
Processing Speed					
Organizational Skills					
Sustained Reading					
Sustained Writing					
Planning					
Problem Solving					
Listening					
Sitting					
Speaking					
Interacting with Others					
Sleeping					
Taking Exams					
Other:					

14. SYMPTOM ASSESSMENT (REQUIRED)

Please rate the frequency/duration and severity (using "x") of the symptoms as related to the disability.

Symptom	**Frequency/Duration 0-4 Scale** 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic	**Severity**			
		Unknown / N/A	**Mild**	**Moderate**	**Severe**
Compulsive Behaviors					
Delusions					
Depressed Mood					
Disordered Eating					
Disorganized Thoughts					
Fatigue/Loss of Energy					
Hallucinations					
Impulsive Behaviors					
Mania					
Obsessive Thoughts					
Panic Attacks					
Phobia (specify:)					
Physiological Symptoms:					
❑ Dizziness					
❑ Fainting					
❑ Racing Heart					
❑ Migraines/Headaches					
❑ Nausea					
❑ Chest Pain					
❑ Shortness of Breath					
❑ Other:					
❑ Other:					
Racing Thoughts					
Self-Injurious Behavior					
Suicidal Ideation					
Suicide Attempts					
Other:					

15. Please list your recommendations for accommodations that could mitigate the symptoms and functional limitations listed above. Please provide an explanation or rationale for the recommendations utilizing data from objective measures, the educational record or other data sources. If available in a separate report, please attach that report.

Accommodation Recommendation	Rationale

16. Certifier Information:

Clinician Name (print)	
Clinician Name (signature)	
Medical Specialty	
License #	
Address	
Phone	
Email	
Date	

Please send this completed form and any additional documentation to:

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