

**PSYCHOLOGICAL DISABILITIES – FUNCTIONAL LIMITATIONS FORM
UNIVERSITY OF ARKANSAS AT PINE BLUFF
DISABILITY SERVICES**

Name: _____ **SSN:** _____ **DOB:** _____

This individual has self-disclosed the following disability or disabilities:

In order to provide appropriate accommodations designed to give the student equal access in the university setting, we need to know how the disability impacts functioning in this setting.

DSM IV Name and Diagnostic Code

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Date diagnosed: _____ **Last visit:** _____

1. Please check which of the following, if any, are affected significantly enough to have a negative impact in a higher education setting.

____ Expression – oral

____ Reception – auditory

____ Perceptual distortions

____ Concentration

____ Expression – written

____ Reception - written

____ Delusions

____ Working in groups

____ Time management/organization

Please explain further if perceptual distortions or delusions occur: _____

2. Does the disability significantly directly affect ability to attend class regularly? If so, why?

3. Does the disability cause a threat to safety of self or others? If so, in what way?

4. What medications does this individual take regularly, and what side effects do these have that might significantly impact education? _____

5. If the diagnosis includes a phobic response to exams, is it to such an extent that the student would not be able to demonstrate knowledge on an exam administered normally? ____ Yes ____ No ____

6. Please rate severity of the disability on a scale of 1 (very mild) to 10 (very severe) ? _____

7. Is the condition chronic? ____ Yes ____ No If no, expected recovery time: _____

Professional license and number: _____

Signature of diagnosing professional:- _____ **Date:** _____