PSYCHOLOGICAL DISABILITES – 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 IV: _____
Axis II: _____ Axis V: _____
Axis III: _____ 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 that 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:_____