OFFICE OF STUDENT LIFE
ACCESSIBLE EDUCATIONAL SERVICES

Psychological Conditions Documentation Form

Student Name: ______________________________ DOB: _____/_____/_____ has requested support services from the Accessible Educational Services (AES) at Indiana University Bloomington (IUB). Documentation provides vital information about the functional limitation of the student's disability and its impact in a post-secondary academic environment.

Please complete all sections of this form and return it as soon as possible so that we may verify the student's eligibility for services. ***This form is not acceptable documentation for Attention Deficit/Hyperactivity Disorders (ADHD) or Learning Disorders (LD)***. Providers may also use their own format as long as the information requested below is included. If this information is not provided, services may be delayed as AES obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650, or mailed to the address at the bottom of this page.

DSM-V Diagnoses (*Please provide both code and descriptor*):
Primary: ____
Secondary: ____
Onset of Symptoms: ___/___/____ Initial visit: ___/___/___ Last appointment (at your practice): ___/___/___
Frequency of visits: □ Weekly □ Bi-weekly □ Monthly □ As needed □ Other If other, list: ________________

Basis on which Diagnosis was made (*check all that apply*)**:**

□ Psycho-educational or neuropsychological assessment (please attach report)
□ Psychological Assessment (please attach report)
□ Structured or unstructured interviews with student
□ Behavioral observations
□ Medical history
□ Suicidal Ideation
□ Other (*Please specify*):
____
____

Assessment of Clinical Manifestations (REQUIRED): Please indicate (☑) each of the symptoms affecting the student as well as **their frequency of occurrence (1-rarely/2-weekly/3-daily)** as related to the student's diagnosis.

☐ Compulsive Behaviors ______
☐ Delusions ________________
☐ Hallucinations ____________
☐ Impulsive Behaviors ________
☐ Mania ________________
☐ Obsessive Thoughts ________
☐ Panic Attacks ______________
☐ Phobia (specify:____________)
☐ Racing Heart ______________
☐ Racing Thoughts ____________
☐ Self-Injurious Behavior _____
☐ Shortness of Breath _________
☐ Suicidal Ideation __________
☐ Suicide Attempts (#_____)
☐ Unable to Leave the House
☐ Disordered Eating
☐ Other ___________________

Does this student currently pose a threat to themselves or others? ☐ Yes ☐ No
If yes, please explain:____
Has this student been □ hospitalized or □ received in-patient care or □ other treatment for this disorder in the past?
If yes, please explain: ____

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Do the student's symptoms fluctuate or worsen under certain conditions? ☐ Yes ☐ No
If yes, please explain: ____

Current Medical Treatment/Intervention Plan (*check all that apply*)**:**
☐ Individual therapy/counseling
☐ Group therapy/counseling
☐ Outpatient treatment program
☐ Inpatient/hospital treatment program
☐ Medication management
☐ Other (*Please specify*):____________________

Are you providing treatment/intervention? ☐ Yes ☐ No
If no, please explain: ____
If yes, how often? ____

Implications for Educational Success/Major Life Activities (REQUIRED): Please indicate area of function affected or limited by the student's psychological diagnosis.

☐ Concentration
☐ Memory
☐ Cognitive functioning
☐ Social interaction
☐ Communication
☐ Complex/abstract thinking
☐ Personal care
☐ Making/keeping appointments
☐ Managing external distraction
☐ Managing internal distraction
☐ Meeting deadlines
☐ Motor skills: ______________
☐ Sleep
☐ Task persistence
☐ Task organization/ prioritization
☐ Time management
☐ Stress management
☐ Other: ________________
☐ Other: ________________

What has the student reported to you regarding the condition's impact on his/her academic progress? This will assist AES in determining accommodations:

____
____
____

Is there any prescribed medication that negatively impacts the student's current academic functioning?
☐ Yes ☐ No If yes, please explain: ____

How long do you anticipate the condition to impact academic achievement?
☐ < 6 months ☐ < 1 year ☐ > 1 year

Certifying Professional

I am verifying that the above-named student's information is correct, the student has an ongoing therapeutic relationship with me or someone in my office, and I am not a relative of the student.

Name (*print*)**:** ______________________________ **Date:** ____/____/____
Profession: ______________________________ **License number:** ____________
Office Address: ____
Phone: ______________ **Fax:** ______________ **Email Address:** ______________
Certifying Professional Signature: ____