COLLEGE of CHARLESTON

CENTER FOR DISABILITY SERVICES

PSYCHOLOGICAL DOCUMENTATION FORM

Client/Patient:_____ **Date:** _____
Last Name First MI

SID#: _____ **DOB:** _____

Diagnosis(es) (DSM, ICD-9): _____
Current GAF: _____ **Date of Diagnosis:** _____ **Date Last Seen:** _____

Description of presenting symptoms, duration and severity of disorder and relevant medical history:

_____

_____

_____

_____

_____

Date(s) of Treatment and Type of Treatment Provided (i.e., medications, therapy): _____

_____

_____

Degree Treatment Successful: _____

What is the expected progression of the disorder?_____

_____

_____

Is the student currently functionally impaired by the above disorder(s)? ____YES ____ NO

Specifically, how is the student impaired or limited in an educational setting, and to what degree?

_____

_____

_____

_____

How likely is the student to be functionally impaired to the same or greater degree 6 months from now:_____ **1 year from now:** _____ **Permanently (chronic):** _____

Name and Address of Health Professional (please print or type)

_____

_____

_____

Phone: _____ **Fax:** _____

_____ _____
Signature and Credentials of Health Professional **Date**