

Student ID Number: _____
Campus Address: _____
Local Phone Number: _____
Date of Birth : _____
Date of Evaluation: _____

Diagnosis

Please list this individual's diagnosis(es) and give a brief explanation of each. _____

Symptoms and Severity

Please list this individual's current symptoms and indicate their severity (mild, moderate, severe). _____

Age of Onset

Age of onset _____ Date of onset _____

Prognosis

Please describe the prognosis. _____

Prescribed Treatment

Please list prescribed treatments, care, assistive devices, etc. and list any activities that would be contraindicated by this individual's condition. _____

Impact on Cognitive Functioning

Please describe current impact of the condition or medication on cognitive functioning. _____

If any objective tests of cognitive functioning have been administered, please attach those test results, including standard scores and percentile ranks, as well as any interpretive summary.

Current Impact of Condition or Medication on Academic Functioning

Please describe the effects of the condition or prescribed medications on academic functioning. _____

