



Cornell University

Student Disability Services  
Cornell Health, Level 5  
110 Ho Plaza  
Ithaca, NY 14853  
Phone: (607) 254-4545  
Fax: (607) 255-1562  
sds.cornell.edu

## Mental Health Disability Assessment Form

This form is to be completed by a certified mental health professional for a Cornell University student.

Student Disability Services (SDS) provides services and accommodations to persons with disabilities to ensure **equal access and opportunity to educational programs and activities. Documentation can aid us in the process** of determining if a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as amended in 2008. These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Understanding of the functional limitations of the condition can help us determine appropriate accommodations for the student.

The information from this completed form will be used to determine a student's eligibility to receive access accommodations. Disability documentation should include the following elements:

- A. Credentials of the evaluator
- B. Current statement of diagnosis
- C. Comprehensive evaluation, including:
  - a. Description of diagnostic methodology
  - b. Relevant history
  - c. Assessment of functional limitations
  - d. Treatment / medication and prognosis
  - e. Accommodation recommendations

For more information, review the documentation guidelines on our website:  
<https://sds.cornell.edu/get-started/documentation-guidelines>

I, , authorize my provider above to release to Student Disability Services the information requested on this form for the purpose of determining appropriate accommodation for my disability while a student at Cornell University.

Signature:  Date:

If signed by person other than patient, state relationship and authority to do so.

Relationship:  Legal Authority:

**Please complete the following:**

Today's Date:

### Student Information

Student Name:  Cornell ID

### Diagnosis

Name of the DSM-5 diagnosis (or ICD-10 code):

Are there any pending diagnoses?

Date of diagnosis:  Date of first contact with client:

Date of last contact:  Frequency of contact:

Consultation with other medical or mental health professional:

Name:  Date:

In addition to the DSM diagnostic criteria, what other information did you collect to arrive at your diagnosis?

- Behavioral observations
- Developmental history
- Rating scales (e.g., Beck Depression Scale, etc.)
- Medical history
- Structured or unstructured clinical interview with the student
- Interviews with others (parents, teachers, spouse or significant others)
- Neuropsychological, psycho educational testing, etc.

(Dates of testing: )

## Diagnosis (continued)

What methods or tools were utilized to assess functional limitation? Please list (or attach under separate cover?)

## History

Is the student currently receiving psychotherapy?

Yes       No

If yes, how often?

Is the student current taking medications?

Yes       No       N/A – not prescribing physician

If yes, describe the impact of the medication on the student's ability to participate in the educational process (whether the impact is negative or mitigating):

Has the student been hospitalized or received in-patient care for this/these disorder(s) in the past?

Yes       No

If yes, what are the dates of these treatments?

Is there evidence of previous treatment by a health care professional?

Yes       No

If yes, please explain:

## Symptom Assessment

Describe how the student is substantially limited by the symptoms (see next two pages for list):

## Symptom Assessment (continued)

Please rate the frequency/duration and severity of the **relevant** symptoms as related to the disability.

**Frequency:** How frequently do limitations occur?

**0**=never, **1**=rarely, **2**=intermittently, **3**=frequently

**Duration:** How long has the student experienced these limitations?

**1**=more than 1 year, **2**=months, **3**=recent acute onset

Mental Health Symptoms	Frequency Scale 0-3 (see scale above)	Duration Scale 1-3 (see scale above)	Severity			Comments
			Mild	Moderate	Severe	
Compulsive Behaviors						
Impulsive Behaviors						
Obsessive Thoughts						
Depressed Mood						
Disordered Eating						
Fatigue/Loss of Energy						
Hypomania						
Racing Thoughts						
Self-Injurious Behavior						
Suicidal Ideation						
Suicide Attempts						
Panic Attacks						
Phobia (specify:						
Anxious Mood						
Unable to Leave House						
Delusions						
Hallucinations						
Other, please specify:						

## Symptom Assessment (continued)

Please rate the frequency/duration and severity of the **relevant** symptoms as related to the disability.

**Frequency:** How frequently do limitations occur?

**0**=never, **1**=rarely, **2**=intermittently, **3**=frequently

**Duration:** How long has the student experienced these limitations?

**1**=more than 1 year, **2**=months, **3**=recent acute onset

Physiological Symptoms	Frequency Scale 0-3 (see scale above)	Duration Scale 1-3 (see scale above)	Severity			Comments
			Mild	Moderate	Severe	
Dizziness						
Fainting						
Racing Heart						
Migraines/Headaches						
Nausea						
G.I. Distress						
Shortness of Breath						
Chest Pain						
Other, please specify:						
Other, please specify						

## Functional Impact Assessment

Please rate the frequency/duration and severity of the **relevant** symptoms as related to the disability.

**Frequency:** How frequently do limitations occur?

**0**=never, **1**=rarely, **2**=intermittently, **3**=frequently

**Duration:** How long has the student experienced these limitations?

**1**=more than 1 year, **2**=months, **3**=recent acute onset

Major Life Activity	Frequency Scale 0-3 (see scale above)	Duration Scale 1-3 (see scale above)	Severity			Comments
			Mild	Moderate	Severe	
Initiating Activities						
Concentration						
Following Directions						
Memorization						
Persistence						
Processing Speed						
Organizational Skills						
Sustained Reading						
Sustained Writing						
Problem Solving						
Listening						
Sitting						
Speaking						
Interacting with Others						
Sleeping						
Self-Care						
Other, please specify:						
Other, please specify:						

### **Impact in Post-Secondary Setting**

Provide comments on daily life impairment experienced by student in a post-secondary setting:

### **Anticipated Progress and Prognosis**

Progress and anticipated prognosis (if relevant, provide information on the cyclical nature or known environmental triggers):

### **Additional Comments**

## Certifier Information

Clinician Name:

Clinician Signature:

Medical Specialty:

License/Certification #:

Address:

Phone:

Email:  Date

## Office Information

To return form or ask questions:

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