Student Intake Form

Student Name: _______________________________   Today’s Date: _____________________

Personal Information

Full Name:  ___________________________________________________________________
Student ID Number:  ____________________________________________________________
Major:  _______________________________________________________________________
Advisor’s Name: _______________________________________________________________

Housing:

☐ On-campus If on-campus, which dorm?  ______________________________
☐ Off-campus

Status (check all that apply)

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Other ☐ Non-degree seeking
☐ Nursing ☐ Master of Social Work (MSW) ☐ Academic ☐ Career Technical Ed (CTE)

Disability Documentation

Please describe your disability in a few words:

________________________________________
________________________________________
Date of original diagnosis and/or onset of disability:

Do you have documentation for this disability? □ Yes □ No
Is your disability permanent or temporary? □ permanent □ temporary
Will you need emergency evacuation assistance? □ Yes □ No
Are you a veteran or ever served in the military? □ Yes □ No
  If yes, which branch? _______________________________________________

**Current Functional Impact**

Describe all current disability-related functional (work, control, perform) impact (frustrations, issues, and/or restrictions) of your disability and how they impact your participation in each of the areas below. If you need additional space, please attach a document.

<table>
<thead>
<tr>
<th>Classes (lectures, laboratory, physical activity, web based)</th>
<th>For Students:</th>
<th>For Staff:</th>
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<tbody>
<tr>
<td>Assignments (reading, writing, calculating, keyboarding, library/research work)</td>
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<td>Related Activities (clinical placement, practicums, internships)</td>
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<td>Communication (speaking, listening, using phones, using email)</td>
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<td>Evaluation (tests, papers, oral reports, group presentations/projects)</td>
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<td>Time Constraints (timed tests, college deadlines, assignment due dates)</td>
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<td>Attendance (class, required activities out of class, residential requirements)</td>
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### Classes
(lectures, laboratory, physical activity, web based)

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### Campus
(mobility, orientation/navigation, transportation)

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### Residence Halls
(roommates, food issues, climate control)

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### Other:

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### Prognosis or Stability of Disability Over Time
Describe the variability or amount of change and possible flair-ups or episodes, if any that can occur with your disability. If this does not pertain to you, please check “none.”

- [ ] None

### Previously Used Services
Understanding previous services used will help LCSC Disability Services best evaluate your request. Please provide as much information as possible.

**Disability-Related Treatments, Accommodations, Medications, Assistive Devices, and/or Services Previously Used**

**Did you receive accommodations and/or services for your disability? (check all that apply)**

- [ ] Preschool
- [ ] Elementary School
- [ ] College or University (give name):
- [ ] Middle School/Jr. High
- [ ] High School
- [ ] Never
What types of services did you receive? (check all that apply and complete as required)

- Resource classes   Hours per week: ____________   IEPs Available:  Yes  No
- Tutoring   Hours per week: ______________________________________________
  Subject Areas: _______________________________________________
- Self-contained classes
- Other. Please describe: _______________________________________________________

Accommodations not used

Have you been granted accommodations in the past that you did not use?  Yes  No

If yes, please explain why you did not use the accommodations or other services:

For each of the following, please describe what you have used and its usefulness:

| Accommodations (examples: extended test time, use of a note-taker, use of a scribe, etc.) | For Student: | For Staff: |
| Modifications (example: allowed to work fewer math problems, write shorter papers, etc.) | | |
| Services (example: worked with a speech or occupational therapist, etc.) | | |
| Assistive Devices (example: screen reader, noise canceling headphones, etc.) | | |
Accommodations
(examples: extended test time, use of a note-taker, use of a scribe, etc.)

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Additional questions

What services do you believe you will need for success at LCSC?

Additional Information You Want to Share About Yourself and/or Your Disability: 
Other Agency/Program Involvement
(please complete information for all services that apply)

☐ Student Support Services (TRIO)

☐ Vocational Rehabilitation:
  Name of Counselor ______________________________________________________
  Phone Number __________________________________________________________

☐ VA Vocational Rehabilitation:
  Name of Counselor ______________________________________________________
  Phone Number __________________________________________________________

☐ Commission for the Blind and Visually Impaired
  Name of Counselor ______________________________________________________
  Phone Number __________________________________________________________

☐ Other (please specify and provide phone numbers)

__________________________________________________________
__________________________________________________________
Authorization

I, ______________________________, authorize LCSC Disability Services to communicate with my instructors about my disability and needs.

Release of Information

In order for Disability Services to assist with academic advising, we will need access to your academic records. All academic records are strictly confidential and will be kept confidential and treated in a professional manner. The following release will authorize the staff of Disability Services to obtain your grades, transcripts from Lewis-Clark State College and other colleges. If you have any questions, please feel free to contact our office.

I, ______________________________, authorize Disability Services to obtain my grade reports, as well as any other academic information needed for my academic advising.

Signature  ____________________________________________________________________

Today’s Date  _________________________________________________________________

FOR OFFICE USE ONLY

Disability Services Staff (Full Name): ____________________________________________

Staff Signature: __________________________________________________________________

Date Reviewed: __________________________________________________________________

Notes as Needed