



**DISABILITY SUPPORT SERVICES
STUDENT INTAKE FORM**

I. General Information

Date: _____

1. Name _____
2. Local Address _____
3. City _____ State _____ Zip Code _____
4. DOB _____ Phone (C) _____ (H) _____
5. E-Mail _____
6. Major _____
7. High School attended _____ Year of graduation _____
8. Have you attended any other college? Y or N.
If yes where did you attend? _____

II. Strengths & Challenges

1. What are your strengths?

2. What is your diagnosed disability? (Check all that apply)

- ADD/ADHD
- Autism Spectrum Disorder
- Blind/ Visually Impaired
- Brain Injury (Acquired or Traumatic)
- Chronic/ Degenerative (specify: _____)
- Dyslexia
- Emotional
- Hearing Loss
- Learning Disability
- Mobility/ Physical (specify: _____)
- Psychiatric (specify: _____)
- Other (specify _____)

3. Please describe your disability and how it affects you (if it does) *in general*.

4. How does your disability affect your performance *as a student*?

5. How do your *strengths* help your performance as a student?

6. Describe any assistive technology or special equipment you use on a regular basis?

7. Are you currently receiving support from any private, state, or government agency? (i.e. psychologist, Mass Rehab)

Agency: _____

Caseworker: _____

Location: _____

Phone Number: _____

III. Educational History

1. What services or accommodations have you used as a student?

2. What accommodations have worked best for you?

3. Did you request your own accommodations or were they provided to you?

4. What were your easiest subjects in school?

5. What were your hardest subjects in school?

6. Skills Review - Please check any areas that you think are problematic for you.

- | | |
|--|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Talking | <input type="checkbox"/> Math |
| <input type="checkbox"/> Self-Management | <input type="checkbox"/> Planning/Organizing |
| <input type="checkbox"/> Networking | <input type="checkbox"/> Social Skills |
| <input type="checkbox"/> Research | <input type="checkbox"/> Critical Thinking |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Technology |
| <input type="checkbox"/> Attention | <input type="checkbox"/> Note-taking |
| <input type="checkbox"/> Test taking | <input type="checkbox"/> Responsibility for Actions |
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Other |

IV. Goals

1. Why are you attending college?

2. What is your long term educational goal?

3. What is your first semester goal?

Student Signature _____ Date _____