Revised 6/2017

JOLIET JUNIOR COLLEGE
1901

1215 Houbolt Road ▪ Joliet, IL 60431

DISABILITY SERVICES

(815) 280-2230 or (815) 280-2941 ▪ Office A-1125

ADD/ADHD, PSYCHOLOGICAL, AND TRAUMATIC BRAIN INJURY DOCUMENTATION

Date:_____ Date of Birth:_____

Name of Student:_____

Dear Medical Professional:
The student whose name appears above has applied for services from the Disability Services Office at Joliet Junior College. In order to verify the presence of a disability and determine the student's eligibility for services, we need your assessment and diagnosis of this student. Please assist the student by completing this form. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

1. What is the diagnosis/impairment?

Date of Diagnosis:_____

Primary Diagnosis:_____

Secondary Diagnosis:_____

2. What were the assessment or evaluation procedures used to make the diagnosis?

3. Briefly describe as appropriate the history of presenting symptoms and past functioning, duration of the disorder, and relevant development, or historical data pertinent to the disability.

4. Is this student a danger to himself or others?

5. What are the major symptoms of the disorder currently manifested by the patient/student, including level of severity?

6. Which medication(s) is the individual currently taking; are there any substantial side effects for this medication(s)?

7. What are the current functional limitations imposed by this disorder?

8. What is the current prognosis? When did you last see this individual?

Please check each of the major life activities listed below that are affected by the disorder. Please indicate the severity of limitations.

Life activity		No Impact	Moderate Impact	Substantial Impact	Unknown
Concentration					
Memory					
Social Interactions					
Managing distractions					
Time management					
Motivation					
Communicating					
Organization					
Self-care					
Stress Management					
Sleeping					
Eating					
Other (explain)					

_____ _____
Signature of Professional Date

_____ _____
Professional's Name (printed) and Title License Number

_____ _____
Street Address Telephone Number

_____ _____
City, State, Zip Code Fax Number