

**DISABILITY SERVICES: INTAKE FORM**  
*CONFIDENTIAL*

*Intake-pg. 1*

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SCU ID #: \_\_\_\_\_

NAME: \_\_\_\_\_

SS#: \_\_\_\_\_

MAILING ADDRESS:

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

TELEPHONE (W): \_\_\_\_\_

TELEPHONE (H): \_\_\_\_\_

TELEPHONE (C): \_\_\_\_\_

E-MAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

SEX: FEMALE \_\_\_\_ MALE \_\_\_\_

*Please select one*

MARITAL STATUS: \_\_\_\_\_

EMERGENCY CONTACT PERSON: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_

***TRANSFER STUDENT BACKGROUND:***

COLLEGES ATTENDED:

DEGREE(S) EARNED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***PERTINENT SMITH CHRISTIAN UNIVERSITY INFORMATION:***

DATE ENROLLED AT SCU: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SCHOOL OF: \_\_\_\_\_

EXPECTED GRADUATION DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ MAJOR: \_\_\_\_\_

CAMPUS: \_\_\_\_\_ DEGREE PLAN: \_\_\_\_\_

ARE YOU RECEIVING FINANCIAL AID? \_\_\_\_\_

IF YES, SPECIFY TYPE:

\_\_\_\_\_  
\_\_\_\_\_

**DISABILITY SERVICES: INTAKE FORM**  
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*Intake-pg.2*

**PLEASE CHECK THE SPECIFIC CONDITION/DISABILITY FOR WHICH YOU SEEK ACCOMMODATIONS:**

- |  |  |
|--|--|
| <input type="checkbox"/> LD (Please specify)   | <input type="checkbox"/> MOBILITY/HAND FUNCTION (ORTHOPEdic) |
| <input type="checkbox"/> ADHD Specify: Combined/Predominately<br>Inattentive/Predominately Hyperactive-Impulsive | <input type="checkbox"/> IMPAIRMENT                          |
| <input type="checkbox"/> TRAUMATIC BRAIN INJURY (TBI)  | <input type="checkbox"/> HARD OF HEARING/DEAF                |
| <input type="checkbox"/> VISUAL IMPAIRMENT/BLINDNESS   | <input type="checkbox"/> SPEECH/LANGUAGE DISORDER            |
| <input type="checkbox"/> OTHER (Please specify) _____  | <input type="checkbox"/> PSYCHOLOGICAL/PSYCHIATRIC DISORDER  |

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**OUTSIDE AGENCY INFORMATION:**

ARE YOU A CLIENT OF VOCATIONAL REHABILITATION, DIVISION OF BLIND SERVICES, DEAF SERVICES BUREAU OR ANY OTHER AGENCY?  YES  NO

*Please select one*

NAME OF AGENCY: \_\_\_\_\_

ADDRESS OF AGENCY: \_\_\_\_\_

COUNSELOR AT AGENCY: \_\_\_\_\_ PHONE #: \_\_\_\_\_

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Please list the specific reasonable accommodations you are requesting:

\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize the Office Disability Services of Smith Christian University to release/receive necessary information deemed relevant to disability accommodation and ODS program eligibility at Smith Christian University. Information may include medical records or reports and/or psychological or psycho educational assessments/records.

DIAGNOSTICIAN NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE #: \_\_\_\_\_

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Forward all documentation of your disability to the Office of Disability Services in order to be registered with ODS. Your registration with ODS is not complete until you meet with a Disability Counselor.**