#

**Student Accessibility Services (SAS)**

**Counseling Center, New York City**

**156 William Street, New York, NY 10038**

 **Telephone: (212) 346-1526**

**Fax: (914) 989-8047**

**Fax: (212) 346-1530**

##  E-mail: disability@pace.edu

Disability Assessment Questionnaire:

General Accommodations

**Patient’s Name: Date:**

**Professional’s name:**

**Medical or other specialty: Degree:**

**State of Licensure and License #:**

**Address 1: Telephone #**

**Address 2: Fax #**

**Date of Initial Contact**:

**Date of Last Contact:**

**Frequency of appointments:**

 **Once a week**

 **Biweekly**

 **Once a month**

 **Once every three to six month**

 **Once a year**

 **On an as needed basis**

**Primary Diagnosis:**

**Other Diagnoses:**

**Severity** (please circle one): **Mild Moderate Severe**

**Explain the severity:**

**Major Life Activities Impacted by condition(s):**

**Interventions**:

**Medications**:

**Side effects**:

**Expected duration of the condition:**

 **Short term (less than 6 months)**

 **Episodic**

 **Long Term (6 months – 1 year)**

 **Chronic (longer than a year with frequent recurrence)**

 **Other (please explain below)**

**Current functional limitation and related symptoms:**

**Impact of limitations and symptoms in the classroom setting:**

**Suggested academic accommodations based on difficulties imposed by the disability**:

**Other comments**:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you very much for your time and assistance. If you have any comments, questions, or concerns, please contact:

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