SC State University
Office of Student Disability Services

INITIAL INTAKE INFORMATION FORM

Academic Year: 20__

Check One	
☐	Spring
☐	Fall
☐	Summer

SECTION I:

Name: _____ **Today's Date:** _____

What do you prefer to be called? _____ **Student ID#:** _____

Date of Birth: _____ **Age:** _____ **Gender/Sex:** _____**Email Address:** _____

Local Address: _____

Permanent Address: _____

Local Phone: _____ **Cell Phone:** _____ **Other Phone:** _____

Circle One: **Okay to leave message** **Okay to leave message** **Okay to leave message**

Classification Circle One: **Freshman** **Sophomore** **Junior** **Senior** **Graduate** **Major:**_____

How many hours are you enrolled or planning to enroll this semester/session? _____

Do you have a copy of your class schedule?

☐**Yes**
☐**No**

Ethnic Background: (Check one)	**Marital Status (Circle One)**	**How did you hear about the Disability Services Office? (Circle One)**
☐**African American**	**Single**	**Orientation**
☐**Hispanic**	**Married**	**Brochure**
☐**Native American**	**Separated**	**Previous Client**
☐**Caucasian**	**Divorced**	**Classroom Presentation**
☐**Asian**	**Widowed**	**Friend/Roommate**
☐**International**	**Partnered**	**Professor/Advisor**
☐**Biracial**	**Renamed**	**RA/GA (Residence Hall)**
☐**Other** _____		

SECTION II:

Have you received services from the Disability Services Office at SC State University previously?

☐**Yes**

☐**No**

If yes, when and what type of services did you received:

_____

_____

Have you received Disability Services from another state or local college or other post-secondary institution?

☐**Yes**

☐**No**

If yes, when and what type of services did you receive?

_____

_____

Do you have a diagnosed disability?

☐**Yes**

☐**No**

Do you have a document to support your disability?

☐**Yes**

☐**No**

What document(s) do you have to support your disability?

_____

_____

What accommodations or aids are you requesting based on your disability to meet your academic needs?

_____

_____

When do you need accommodations?

Are you currently receiving services from SC Vocational Rehabilitations Department in the past?

☐**Yes**

☐**No**

If so, what county and who is your counselor? _____

If you are a current client Vocational Rehabilitation Department, what type of services are you receiving from them?

_____

If you were a previous client of SC Vocational Rehabilitation Department when and why did your services terminate?

Are you in good physical health?

☐**Yes**

☐**No**

Are you currently taking any medication?

☐**Yes**

☐**No**

If yes, list medications?

_____

SECTION III:

Name of person to contact in emergency:

Relationship to you: _____ Phone: _____

Signature: _____ Date: _____

*****THIS SECTION TO BE COMPLETED BY DISABILITY SERVICES STAFF!*****

DISPOSITION

Name: _____ Date: _____

Student ID#: _____ Date Accommodation Requested: _____

1. **Have documentations been provided to support the disability?**
   - ☐**Yes**
   - ☐**No**

   If no, have the necessary documents been requested from the student?
   - ☐**Yes**
   - ☐**No**

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1. **Accepted as Client:**
   - ☐**Individual**
   - ☐**Transferred to another counselor**
2. **Referred to other SCSU services**
   - ☐**Career Services**
   - ☐**Health Services**
   - ☐**Other _____**
3. **Outside Referral**
   - ☐**SC Vocational Rehabilitation Department**
   - ☐**School for Deaf and Blind**
   - ☐**Other _____**
4. **Type of accommodations provided: _____**
5. **Date accommodations were provided: _____**
6. **Terminated: No further Services:**
   - ☐**Needed**
   - ☐**Desired**
   - ☐**Withdrawal**
7. **Was follow-up appointed scheduled?**
   - ☐**Yes**
   - ☐**No**

   No, if so, date? _____

Comments:

Counselor's Signature _____ Date: _____