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Disability Services Request for Accommodations Intake Form

When evaluating accommodations, we will consider any information including but not limited to:

- **Your description of your needs**
- **Records of past accommodations and services from high school**
 - **Formal psychological or medical evaluations**
 - **Letters from past health, education or service providers**

We need information to determine your barriers a school context. Consider how your disability effects your mobility, communication, interaction with others, and learning (reading, writing, and math).

Date: _____

Name: _____

Student ID: _____

Date of Birth: _____ Age: _____

Address: _____

Phone #: _____

Email: _____

Primary Campus: _____

Program of Study: _____

Starting Term: _____

High School: _____

IEP, 504 Plan: ___ Yes ___ No

Have you ever been enrolled in college? ___ Yes ___ No If so, where: _____

Accommodations at the college: _____

1. Do you now, or have you ever been told that you have one of the following disabilities:

- | | |
|--|---|
| <input type="checkbox"/> Acquired Brain Injury | <input type="checkbox"/> Neurological (i.e. cerebral palsy, epilepsy) |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Personality Disorder |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Blindness or Low-Vision | <input type="checkbox"/> Psychological/Psychiatric (i.e. depression) |
| <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Other (medical): _____ |
| <input type="checkbox"/> Learning Disability | |

What accommodations are you requesting?

- | | |
|---|--|
| <input type="checkbox"/> Extra test taking time | <input type="checkbox"/> Interpreter |
| <input type="checkbox"/> Testing in a quiet area | <input type="checkbox"/> Accessible classrooms |
| <input type="checkbox"/> Copies of lecture notes or PowerPoints | <input type="checkbox"/> Recording of lectures |
| <input type="checkbox"/> Read Aloud | <input type="checkbox"/> Note-taker |
| <input type="checkbox"/> Speech to Text | <input type="checkbox"/> Scribe |
| <input type="checkbox"/> Braille or low-vision assistance | <input type="checkbox"/> Other: _____ |

Have you ever or are you now working with any outside agencies (Vocational Rehabilitation, a therapist etc.)?

Do you have outside documentation of your disability?

Are you on any medications?

What academic barriers have you faced in the past?

- | | |
|---|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Math | <input type="checkbox"/> Completing assignments on time |
| <input type="checkbox"/> Test taking | <input type="checkbox"/> Organization |
| <input type="checkbox"/> Study Skills | <input type="checkbox"/> Motivation |
| <input type="checkbox"/> Comprehending Concepts | |

If an emergency occurs on campus, will you need special services or support to exit safely? If so, please explain.