

# COLLEGE OF CHARLESTON

Center for Disability Services  
Phone (843) 953-1431

160 Calhoun Street

Charleston, South Carolina 29424  
Fax (843) 953-7731

## PSYCHIATRIC DOCUMENTATION FORM

Client/Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
Last Name First MI

SID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis(es) (DSM, ICD-9): \_\_\_\_\_

Current GAF: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Description of presenting symptoms, duration and severity of disorder and relevant medical history:

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Date(s) of Treatment and Type of Treatment Provided (i.e., medications, therapy): \_\_\_\_\_

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Degree Treatment Successful: \_\_\_\_\_

What is the expected progression of the disorder? \_\_\_\_\_

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Is the student currently functionally impaired by the above disorder(s)?  YES  NO

Specifically, how is the student impaired or limited in an educational setting, and to what degree?

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How likely is the student to be functionally impaired to the same or greater degree 6 months from now: \_\_\_\_\_ 1 year from now: \_\_\_\_\_ Permanently (chronic): \_\_\_\_\_

Name and Address of Health Professional (please print or type)

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Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature and Credentials of Health Professional

Date