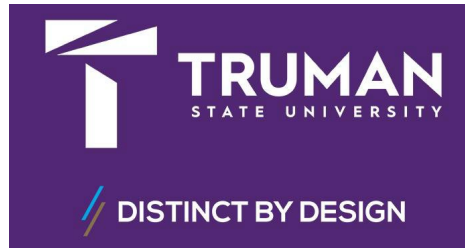


Office of Student Access
and Disability Services
(660)785-4478 Phone
(660) 785-4490 Fax



Pickler Memorial Library
109A
100 E. Normal St
Kirksville, MO 63501

Client Information Form and Application for Accommodations Student Access and Disability Services

Name: _____ Date: Click or tap to enter a date.
Banner ID: _____ Date of Birth: Click or tap to enter a date.
Telephone#/Mobile: (_____)_____-____ Truman email address: _____@truman.edu
Campus/Kirksville Address: _____
Year: Will be a Freshman Currently a Freshman Sophomore Junior Senior
*How many hours earned as of this application: _____
 Graduate student

Personal Information

My Major: _____ My GPA is: _____ University or High School

English is my 1st language: Yes NO, my first language: _____

I am currently: New freshman enrolling Progressing as expected Progressing better than expected

On probation Progressing worse than expected, please explain: _____

1. Please explain why you contacted the Office of Student Access and Disability Services/what is the barrier(s) you are experiencing accessing your classroom or classroom/educational material?:

2. Do you work while attending school? NO YES (if yes, describe your position and indicate how many hours you work per week):

3. There have been significant changes in my life during the past year (if yes, please provide additional details): YES NO

Educational History

1. Have you ever repeated a grade? NO YES If "yes", please list the grade(s): _____

2. Have you ever skipped a grade? NO YES If "yes", please list the grade(s): _____

3. Have you ever been enrolled in special education or remedial classes in K-12? NO YES

a. If "yes", please list the classes and grades(s): _____

4. Have you received accommodations, modifications, or special services while attending High School:

High School Community College University

If so, please describe _____

5. If you have not received accommodations in High School or College previously, what accommodations are you requesting for classroom access/to remove a barrier?

6. Have you ever been suspended from school or university? NO YES If "yes" please explain:

7. Have you ever been on academic probation? NO YES If "yes" please explain:

8. List the high schools and colleges you have previously attended:

School	City	Dates Attended	Degree Earned	GPA

9. ACT Score: _____ SAT Score: _____

History and Nature of Disability

1. Have you ever been diagnosed with a learning disability? NO YES If "yes" when and please list Specific Learning Disability:

2. Describe your learning difficulties or academic challenges: _____

3. Have you had accommodations in the past that have helped? NO YES If "yes" please list: _____

4. Indicate the area(s) in which you experience academic difficulty:
READING WRITING MATHEMATICS SPELLING GRAMMAR NOTE-TAKING
HANDWRITING MEMORY ORGANIZATION TIME MANAGEMENT PLANNING
INITIATING TASKS OTHER, PLEASE EXPLAIN: _____

4. When did you first notice the difficulties above: _____
5. Describe your academic strengths: _____
6. On average how many hours per week do you study? Less than 10 10-15 15-20 20-25
25-30 30-35 More than 35
7. How many course hours do you have or anticipate having this semester? _____
8. How would you rate your study skills? Below average Average Above Average
9. How much effort/planning do you put into studying? Below Average Average Above Average
10. Do you believe there is room for improvement in your study skills? YES NO POSSIBLY
11. How would you rate your class attendance? 100% 90% 80% 70% I attend 60% or less
12. Do you believe there is room for improvement in your class attendance? YES NO POSSIBLY
Please describe any other demands upon your time (internships, family, activities, athletics, fraternities, sororities, etc.): _____

Medical History

1. To your knowledge, did you experience any trauma or complications at birth? NO YES If "yes" please explain:

2. Did you have any major childhood illnesses, diseases, surgeries, etc.? NO YES If "yes" please explain:

3. Have you ever been diagnosed with a psychiatric disorder? NO YES If "yes" please explain:

4. Have you participated in formal counseling in the past? NO YES On-campus Off-Campus

If "yes" in the past, but not currently please provide details:

5. Do you currently participate in formal counseling? NO YES On-campus Off-Campus

Please provide details:

6. Have you ever experienced head trauma and/or lost consciousness? NO YES If "yes" please explain:

7. Have you ever had a seizure? NO YES If "yes" please explain:

8. Are you currently being treated for any medical condition? NO YES If "yes" please explain:

9. Have you ever been diagnosed and treated for ADHD? NO YES in the past currently If "yes" please explain:

10. Are you currently taking any prescription medications? NO YES If "yes" please explain medication and condition:

11. Do you have any significant vision problems? NO YES If "yes" please explain:

12. Do you have any significant hearing problems? NO YES If "yes" please explain:

13. Do you drink alcohol? NO YES If "yes" how many drinks per week:

14. Do you use any other substances not addressed above? NO YES If "yes" please explain:

Student Signature

Click or tap to enter a date.

Date: