



Disability Resources for Students Office
Student Intake Information

Program _____ Today's Date _____

First Name	Middle Initial	Last Name
CPTC Student ID #		Phone (Okay to leave message? (circle one) Yes No
Date of Birth (mm/dd/yy)		E-mail Address @students.cptc.edu

Disability Information

Briefly describe any challenges or barriers you face that you feel may impact your education:

Please list any current medication and side effects that could affect your academic success:

Please indicate your disability/ies or health condition (s): MARK ALL THAT APPLY & include diagnosis date (if known)

Sensory	Learning	Speech or Language
<input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Vision Loss or Blind (circle one) <input type="checkbox"/> Blind <input type="checkbox"/> Sensory Processing Issues	<input type="checkbox"/> ADHD <input type="checkbox"/> Specific Learning Disability _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Apraxia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Aphasia <input type="checkbox"/> Other _____
Psychological/Emotional	Mobility	Neurological
<input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Post-Traumatic Stress <input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Other _____	<input type="checkbox"/> Autism Spectrum <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Tourette's <input type="checkbox"/> Other
Chronic or Acute Conditions		Other, please describe
<input type="checkbox"/> Cancer <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Immune disorder <input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Cardiac/Cardiovascular <input type="checkbox"/> Asthma or Pulmonary	_____ _____ _____

Please mark all applicable areas that are affected by your disability/ites or health condition

<input type="checkbox"/> Reading	<input type="checkbox"/> Attention/Concentration	<input type="checkbox"/> Activity restrictions (For example: heavy lifting, walking, standing)
<input type="checkbox"/> Writing Papers	<input type="checkbox"/> Organization	_____
<input type="checkbox"/> Handwriting/Fine motor skills	<input type="checkbox"/> Sitting	_____
<input type="checkbox"/> Computer Keyboarding	<input type="checkbox"/> Standing	<input type="checkbox"/> Other
<input type="checkbox"/> Use of computer screen	<input type="checkbox"/> Class Participation	_____
<input type="checkbox"/> Information processing	<input type="checkbox"/> Group participation	<input type="checkbox"/> Other
<input type="checkbox"/> Memory/Information recall	<input type="checkbox"/> Emotional management	_____
<input type="checkbox"/> Reasoning	<input type="checkbox"/> Endurance	_____
<input type="checkbox"/> Math/Numerical logic		_____

What classroom/academic or workplace adjustments/accommodations have you had in the past?

General Questions & Other Information

How did you hear about Disability Resources?

What is your educational goal?

Are you enrolled in a specific program? If so, which one?

Is there anything else you would like to make DRS aware of concerning your medical status and/or educational goals?

Mark all that apply to you, if any:	Mark all that apply to you, if any:
<input type="checkbox"/> Veteran	<input type="checkbox"/> Client of Division of Vocational Rehabilitation (DVR)
<input type="checkbox"/> Active Military	<input type="checkbox"/> Client of Division of Social & Health Services (DSHS)
<input type="checkbox"/> Running Start	<input type="checkbox"/> Client of Division of Labor & Industries (L&I)
<input type="checkbox"/> Adult Basic Education	<input type="checkbox"/> Client of Department of Services for the Blind (DSB)
<input type="checkbox"/> English Language Program	<input type="checkbox"/> Other _____

If approved for services:

- I understand that students who receive reasonable accommodations for disability must meet essential academic and conduct standards. CPTC's academic and conduct standards can be found online.
- I am aware that my rights and responsibilities are outlined on the DRS page on CPTC's website.
- I understand that it is my responsibility to discuss questions or concerns I have regarding accommodations with DRS in a timely manner.
- I give DRS permission to discuss this information, my accommodations, and other relevant information with faculty, advisors, administrators and/or staff to further my educational goals. I understand DRS will enter my disability status in the Student Management System for confidential statistical purposes.

Student Signature: _____ **Date:** _____