

<https://>

Disability Assessment Questionnaire: Academic Accommodations

Patient's Name:

Date:

Professional's name:

Medical or other specialty:

Degree:

State of Licensure and License #:

Address 1:

Telephone #

Address 2:

Fax #

Date of Initial Contact

Date of Last Contact:

Frequency of appointments:

Once a week

Biweekly

Once a month

Once every three to six month

Once a year

On an as needed basis

Primary Diagnosis:

Other Diagnoses:

Severity

Explain the severity:

Major Life Activities Impacted by condition(s):

Interventions

Medications

Side effects

Expected duration of the condition:

Short term (less than 6 months)

Episodic

Long Term (6 months - 1 year)

Chronic (longer than a year with frequent recurrence)

Other (please explain below)

Current functional limitation and related symptoms:

Impact of limitations and symptoms in the classroom setting:

Suggested academic accommodations based on difficulties imposed by the disability

Other comments

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you very much for your time and assistance. If you have any comments, questions, or concerns, please contact:

Student Accessibility Services  
Pace University  
161 William St, 10<sup>th</sup> Floor New York, NY 10038  
(212) 346-1199  
[sasnyc@pace.edu](mailto:sasnyc@pace.edu)

**PACE UNIVERSITY**

Student Accessibility Services

---