Provider: _____
Date: _____ ***Day:*** _____
: ***am/pm***

NEW MEXICO TECH
SCIENCE • ENGINEERING • RESEARCH UNIVERSITY

Office of Counseling and Disability Services

CLIENT INFORMATION

REQUEST FOR DISABILITY SERVICES

*Date:*_____

Please complete information as completely as possible. If you have any questions about any of the information, please ask us.

Banner ID#: _____

Name: _____ **Age:** _____ **DOB:** _____

PO Box C/S #: _____ **On or off campus address:**_____

Home address (if different than physical address) : _____ **City:** _____ **State:** _____ **Zip:** _____

NMT email: _____ **Phone #:** _____ **(wk #)** _____

Whom may we contact in case of emergency?: _____
Email: _____ **Phone:**_____ **Relationship:**_____

Student Status	**Year in School**	**Ethnicity:**	**Sex:**	**Marital Status:**
		(optional)	(optional)	(optional)
☐ Full-time	☐ Freshman	☐ American Indian/Native American	☐ Male	☐ Single
☐ Part-time	☐ Sophomore	☐ Asian	☐ Female	☐ Cohabiting
☐ Prospective	☐ Junior	☐ Black/African American		☐ Married
	☐ Senior	☐ Hispanic/Latino		☐ Divorced
	☐ Graduate	☐ White/Anglo		☐ Separated
		☐ Other (specify) _____		☐ Widowed

ACADEMIC DATA:

Is this your first semester at Tech? YES or NO
If not, date of first semester at Tech: _____ **Are you a transfer student?** YES / NO
Major area of study: _____ **Advisor:** _____
Current GPA? _____ **How are your grades this semester? (circle one)** Excellent Good Fair Poor
Has your academic performance changed? YES / NO
If so how?
_____
_____
_____
_____
_____
_____
_____
_____
_____

EMPLOYMENT DATA:

Are you working? YES / NO **If so how many hours per week?** _____
Where do you work? _____
What are your principal job duties?_____

DISABILITY INFORMATION:

Please describe your disability: _____
_____
_____
_____

When were you diagnosed with your disability? _____
By whom? _____

Do you take any medication for your disability? Please list and describe. _____
_____
_____
_____

Do you currently have a primary care provider for your disability? (circle one) YES / NO
Name and Profession (e.g. M.D., RN, PA, psychologist, social worker)
_____
Address: _____
Telephone Number:_____

Which of the following major life activities does your disability impair?

□ Caring for self	□ Reaching	□ Sitting
□ Interacting with others	□ Thinking	□ Bowel
□ Breathing	□ Toileting	□ Respiratory
□ Working	□ Digestive	□ Endocrine
□ Reading	□ Brain	□ Lifting
□ Bladder	□ Circulatory	□ Sleeping
□ Neurological	□ Hearing	□ Concentrating
□ Normal Cell Growth	□ Seeing	□ Eating
□ Walking	□ Speaking	□ Bending
□ Standing	□ Learning	□ Communicating
□ Other Please specify _____	□ Reproductive	□ Immune System

How does your disability limit your academic performance? _____
_____
_____

Please describe the issues that you are experiencing in class/housing/other setting that require accommodations _____
_____
_____

Have you received accommodations for your disability(ies) in the past? (circle one) YES / NO
Where (list previous institutions)? _____
_____

Please describe the types of accommodations you have received or are requesting_____
_____

Any other concerns that you would like to discuss?
_____
_____

Limits of confidentiality

The State of New Mexico legally recognizes that communication between a counselor and her/his client as privileged and confidential. Your disability records do not become part of your educational records.
We will not disclose your contacts with us to your spouse/partner, your parents, professors, or anyone else without your permission. There are few narrow exceptions:

- If you are in imminent danger to yourself or are a significant danger to someone else, we have a legal obligation to break confidentiality to protect you and/or others.
- You records can also be subpoenaed by a court of law (e.g. if you claimed emotional damages in a lawsuit).
- If you are abusing children or vulnerable adults **or** inform us concerning someone who is, then we have a legal responsibility to report this to the proper authorities. Such a report could potentially lead to disclosure of your being a client and require testimony concerning the suspected abuse.
- We also reserve the right to consult with your primary care provider at the NMT Student Health Center, when appropriate.
- It is the policy of NM Tech Office of Counseling and Disability Services to involve the Behavior Intervention Team, Dean of Students, and/or Residential Life if there is a pressing safety issue.

Emergency Contact

By providing us with an emergency contact (page 1) you have given us permission to contact this/these person(s) if an emergency arises in regards to your health or safety.

I have read and understand the limits of confidentiality.

_____ _____
Client Signature Date

_____ _____
Disability Counselor/Director Signature Date

Revised 06/16