

# Confidential Health Assessment

VR-26 (6/15)

This form gathers information on your general health. The information is important and will help us in the eligibility and vocational planning process. This information is confidential and will not be shared outside of ACCES-VR without your permission.

NAME:	<i>Last</i>	<i>First</i>	MI	DATE
MAILING ADDRESS: <i>Street</i>		<i>Apartment and/or Building Number</i>		
<i>City</i>	<i>State</i>	<i>Zip Code</i>	DATE OF BIRTH	
Would you describe your health as:				
<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor				
When was your last general physical examination?				
..... <i>date</i>				
Your doctor or clinic's name, address, and telephone number				

*Please check the box(es) that best describes you*

<i>Do you have any difficulty with:</i>	No Difficulty	Some Difficulty	Cannot Do
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using your right foot / leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using your left foot / leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using your right hand / arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using your left hand / arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above your shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing arithmetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Do you now have or have you had:</i>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>		Speech Problems	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>		Head Injury	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>		Cerebral Palsy	<input type="checkbox"/>
Orthopedic Limitations	<input type="checkbox"/>	<input type="checkbox"/>		Multiple Sclerosis	<input type="checkbox"/>
Mental / Emotional Conditions	<input type="checkbox"/>	<input type="checkbox"/>		Muscular Dystrophy	<input type="checkbox"/>
Substance Use Disorders	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>
Allergies / Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>
Respiratory I Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Skin Disease/ Rashes	<input type="checkbox"/>
Ulcers, Colitis	<input type="checkbox"/>	<input type="checkbox"/>		Cancer	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		Learning Disability	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		HIV Related Diseases	<input type="checkbox"/>
Seizure Disorder/ Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Other.	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

*if you answered "Yes to any of the above, please describe how it might affect vocational training or your ability to work.*

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<i>Do you have difficulty working</i>	<b>No</b>	<b>Some</b>	<b>Cannot Do</b>		<b>No</b>	<b>Some</b>	<b>Cannot do</b>
<i>Where there is / are:</i>	<b>Difficulty</b>	<b>Difficulty</b>	<b>Difficulty</b>		<b>Difficulty</b>	<b>Difficulty</b>	<b>Difficulty</b>
<i>Temperature / humidity changes</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Dust / fumes	<input type="checkbox"/>	<input type="checkbox"/>
Unprotected heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Loud noises	<input type="checkbox"/>	<input type="checkbox"/>
Moving machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High stress	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other situations:</i>						<input type="checkbox"/>	<input type="checkbox"/>

Can you work full time?  Yes  No

Do you need special parking?  Yes  No

What special accommodations do you need?  wheelchair  hearing aid  cane / walker  TTY  attendant  interpreter  others

If you answered "**No**", how many hours a day do you feel you can work? \_\_\_\_\_ hours

Do you have any other physical or mental condition which might affect vocational training or your ability to work? If so, please explain. ....

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Are you currently taking any medication? if so, please explain. ....

.....

*I certify, by my signature below, that this information is complete and true to the best of my knowledge.*

Signature

Completed by

Please feel free to attach additional explanation(s)