**MAINE DEPARTMENT OF LABOR**

**DIVISION OF VOCATIONAL REHABILITATION**

HEALTH CHECKLIST

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME** |  | **DATE** |  | **AGE** |  |

ARE YOU LEFT HANDED  RIGHT HANDED

**A. PLEASE SUMMARIZE THE MOST IMPORTANT PROBLEM THAT INTERFERES WITH YOUR**

**USUAL TYPE OF WORK. HOW LONG HAVE YOU BEEN BOTHERED AND IS THE PROBLEM**

**GETTING BETTER OR WORSE?**

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**B.** **DO YOU CURRENTLY HAVE DIFFICULTY WITH:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | | YES | NO |
| 1. HEARING |  |  | 19. STANDING | |  |  |
| 2. SEEING |  |  | 20. WALKING | |  |  |
| 3. SPEAKING |  |  | 21. KNEELING | |  |  |
| 4. FAINTING |  |  | 22. SITTING | |  |  |
| 5. SEIZURES |  |  | 23. LEARNING | |  |  |
| 6. CHEST PAIN |  |  | 24. READING | |  |  |
| 7. SHORTNESS OF BREATH |  |  | 25. CONCENTRATING | |  |  |
| 8. CHRONIC COUGH |  |  | 26. REMEMBERING | |  |  |
| 9. DIGESTION |  |  | 27. GETTING ALONG WITH PEOPLE | |  |  |
| 10. GYNECOLOGICAL PROBLEMS |  |  | 28. NERVOUSNESS (ANXIETY/PANIC) | |  |  |
| 11. SWELLING OF HANDS/LEGS |  |  | 29. DEPRESSION | |  |  |
| 12. WEAKNESS/PAIN IN HANDS/ARMS |  |  | 30. STRESS TOLERANCE | |  |  |
| 13. WEAKNESS/PAIN IN LEGS/FEET |  |  | 31. SLEEP | |  |  |
| 14. NUMBNESS |  |  | 32. ENERGY/STAMINA | |  |  |
| 15. SKIN PROBLEMS |  |  | 33. HALLUCINATION/DELUSION | |  |  |
| 16. LIFTING/BENDING |  |  | 34. OTHER |  | | |
| 17. CLIMBING (STAIRS) |  |  | 35. HAVE YOU EVER BEEN UNCONSCIOUS | |  |  |
| 18. BALANCING |  |  |  | |  |  |

**C. HAVE YOU EVER HAD, OR BEEN TOLD YOU HAVE:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | | | YES | NO |
| 1. HIGH BLOOD PRESSURE |  |  | 8. EATING DISORDER | | |  |  |
| 2. HEART TROUBLE |  |  | 9. KIDNEY OR URINARY TROUBLE | | |  |  |
| 3. DEVELOPMENTAL DISABILITY |  |  | 10. ARTHRITIS | | |  |  |
| 4. ASTHMA OR LUNG DISEASE |  |  | 11. DIABETES | | |  |  |
| 5. TUBERCULOSIS |  |  | 12. CANCER | | |  |  |
| 6. GASTROINTESTINAL PROBLEM |  |  | 13. HEPATITIS B & C | | |  |  |
| 7. PSYCHIATRIC/EMOTIONAL DISORDER |  |  | 14. OTHER INFECTIOUS DISEASES | |  | | |
|  |  |  | 15. OTHER |  | | | |

**D. HOW MUCH DO YOU USE:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TOBACCO |  | ALCOHOL |  | | | | OTHER DRUGS | |  | |
| DO YOU HAVE A HISTORY OF DEPENDENCY ON DRUGS? | | | | |  | | | ALCOHOL | |  |
| IF SO, PLEASE IDENTIFY YOUR DRUG(s) OF CHOICE? | | | |  | | | | | | |
| IF SO, WHAT IS THE DATE OF YOUR SOBRIETY? | | |  | | | | | | | |
| HOW OFTEN DO YOU ATTEND AA, NA, OR OTHER PROGRAMS | | | | | |  | | | | |

**E. ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (Please mention both prescription & non-prescription or over-the-counter drugs)**

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| --- | --- |
| WHAT MEDICINES (Dosage) | PURPOSE (For what condition) |
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**F. DO YOU USE A CANE, BRACE, WHEELCHAIR, HEARING AID, OR OTHER ASSISTIVE DEVICE:**

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| --- | --- | --- |
| YES  NO | PLEASE SPECIFY |  |

|  |  |  |  |
| --- | --- | --- | --- |
| DATE: |  | SIGNATURE OF APPLICANT |  |

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| --- | --- |
| Comments: |  |
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