**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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| --- |
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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)**

|  |  |
| --- | --- |
| 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:**

|  |  |  |
| --- | --- | --- |
| YES [ ]  NO [ ]  | PLEASE SPECIFY |       |

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

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