N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
VOCATIONAL REHABILITATION

HEALTH CHECK LIST

INDIVIDUAL NAME: _____ **DATE:** _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

A. DO YOU CURRENTLY HAVE DIFFICULTY WITH: (CHECK ALL THAT APPLY)

- ☐ Hearing
- ☐ Seeing
- ☐ Speaking
- ☐ Fainting
- ☐ Seizures
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Digestion
- ☐ Gynecological Problems
- ☐ Weakness/Pain in Hands/Arms
- ☐ Swelling of Hands/Legs
- ☐ Weakness/Pain in Legs/Feet
- ☐ Numbness
- ☐ Skin Problems
- ☐ Lifting/Bending
- ☐ Climbing (Stairs)
- ☐ Balancing
- ☐ Standing/Walking/Running
- ☐ Kneeling
- ☐ Sitting
- ☐ Learning
- ☐ Reading
- ☐ Concentrating
- ☐ Remembering
- ☐ Getting Along with People
- ☐ Nervousness (Anxiety/Panic)
- ☐ Depression
- ☐ Stress Tolerance
- ☐ Sleep
- ☐ Energy/Stamina
- ☐ Hallucinations/Delusion
- ☐ Other: _____

B. HAVE YOU EVER HAD, OR BEEN TOLD THAT YOU HAVE, PROBLEMS WITH ANY OF THE FOLLOWING: (CHECK ALL THAT APPLY)

- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Learning or Developmental Disability
- ☐ Asthma or Lung Disease
- ☐ Tuberculosis
- ☐ Gastrointestinal Problems
- ☐ Psychiatric or Emotional Disorders
- ☐ Eating Disorder
- ☐ Kidney or Urinary Trouble
- ☐ Arthritis
- ☐ Diabetes
- ☐ Cancer
- ☐ Infectious Diseases
- ☐ Other: _____

C. HAVE YOU EVER BEEN TREATED FOR PROBLEMS WITH ALCOHOL ☐ OTHER DRUGS ☐

Do you attend AA, NA, or Other Program? _____

D. HAVE YOU BEEN TREATED FOR ANY INJURIES OR CONDITIONS: IF YES:

INJURY/CONDITION/SURGERY	CURRENT LIMITATIONS

HEALTH CHECK LIST

E. ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (Please mention both prescription and non-prescription or over-the-counter drugs.) (Please show medication, dosage, and purpose (for what condition).

_____

_____

_____

_____

_____

_____

_____

F. DO YOU USE A CANE ☐ BRACE ☐ WHEELCHAIR ☐ HEARING AID ☐
OR OTHER ASSISTIVE DEVICE? _____

G. NAMES OF PHYSICIANS, CLINICS, & THERAPISTS MOST FAMILIAR WITH YOUR HEALTH: (INDICATE NAME, ADDRESS, AND DATE OF TREATMENT)

_____

_____

_____

_____

_____

H. HOSPITALS, TREATMENT OR REHABILITATION PROGRAMS WHERE YOU WERE AN IN-PATIENT? (SHOW DATES, NAME AND ADDRESS).

_____

_____

_____

I. 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 WORSE OR BETTER: _____

_____

J. DO YOU HAVE: Medicaid ☐ Medicare ☐ Workers' Comp. ☐ Health Insurance or HMO ☐

_____
SIGNATURE OF COUNSELOR

SIGNATURE OF APPLICANT

DATE: _____ **DATE:** _____