MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
DIVISION OF VOCATIONAL REHABILITATION

HEALTH ASSESSMENT QUESTIONNAIRE

NOTE ▸ THIS QUESTIONNAIRE WILL BE USED BY VOCATIONAL REHABILITATION TO ASSESS YOUR CURRENT HEALTH AND TO EVALUATE THE NEED FOR FURTHER MEDICAL INFORMATION.

PART I. IDENTIFICATION INFORMATION

LAST NAME	FIRST NAME	MI

WHAT IS YOUR DISABILITY?

IN YOUR OWN WORDS, HOW DOES YOUR DISABILITY INTERFERE WITH YOU GETTING OR HOLDING A JOB?

PART II. CURRENT MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN

NAME OF DOCTOR		DATE OF LAST VISIT
ADDRESS		REASON
DATES OF TREATMENT	TELEPHONE ( )	

ARE YOU **CURRENTLY** RECEIVING TREATMENT FOR ANY PHYSICAL OR MENTAL PROBLEM?

☐ YES ☐ NO IF YES, PROVIDE A BRIEF DESCRIPTION

ARE YOU **CURRENTLY** TAKING ANY MEDICATIONS?

☐ YES ☐ NO IF YES, LIST MEDICATIONS

LIST ALL MEDICAL PROFESSIONALS FAMILIAR WITH YOUR DISABILITY.

NAME OF DOCTOR(S)		NAME OF DOCTOR(S)	
ADDRESS		ADDRESS	
DATES OF TREATMENT	TELEPHONE ( )	DATES OF TREATMENT	TELEPHONE ( )

LIST ANY HOSPITALS WHERE YOU HAVE RECEIVED TREATMENT FOR YOUR DISABILITY.

NAME OF HOSPITAL (MOST RECENT HOSPITALIZATION)	NAME OF HOSPITAL
ADDRESS	ADDRESS
DATES OF TREATMENT	DATES OF TREATMENT

PART III. REPORTED MEDICAL HISTORY

DURING THE **PAST TWO YEARS**, HAVE YOU **RECEIVED TREATMENT** FOR ANY OF THE FOLLOWING AREAS:

A. **ENT:** EYES, EARS, NOSE, THROAT ☐ YES ☐ NO

B. **NEUROLOGICAL:** FREQUENT HEADACHES, DIZZINESS, STROKE, EPILEPSY, SEIZURE DISORDER ☐ YES ☐ NO

HAVE YOU EVER HAD A HEAD INJURY OR CONCUSSION? ☐ YES ☐ NO

C. **RESPIRATORY:** BREATHING, CHEST/LUNGS, CHRONIC COUGH, SHORTNESS OF BREATH, EMPHYSEMA, ASTHMA ☐ YES ☐ NO

D. **CARDIOVASCULAR:** HEART, BLOOD VESSELS, RHEUMATIC FEVER, MURMUR, PALPITATION, CHEST PAINS, HIGH BLOOD PRESSURE ☐ YES ☐ NO

E. **INTERNAL:** STOMACH, CHRONIC INDIGESTION, ULCERS, COLITIS, GALL BLADDER, LIVER, KIDNEY, BLADDER, PROSTATE, GENITOURINARY ☐ YES ☐ NO

F. **ENDOCRINE:** DIABETES, THYROID ☐ YES ☐ NO

G. **ORTHOPEDIC:** NEURITIS, ARTHRITIS, GOUT, ANY DISORDER OF THE MUSCLES, BONES, OR JOINTS ☐ YES ☐ NO

H. **ONCOLOGY:** CANCER, TUMOR, CYST, OR ANY OTHER DISORDER OF THE SKIN OR LYMPH GLANDS ☐ YES ☐ NO

I. **PSYCHIATRIC:** DEPRESSION OR OTHER EMOTIONAL DISORDER ☐ YES ☐ NO

J. **INFECTIOUS DISEASES:** HEPATITIS, TUBERCULOSIS, HIV/AIDS ☐ YES ☐ NO

K. **SUBSTANCE ABUSE:** ALCOHOLISM, DRUGS ☐ YES ☐ NO

L. **OTHER:** HAD, OR BEEN ADVISED TO HAVE, ANY SURGICAL PROCEDURES, HOSPITALIZATIONS, MEDICAL EXAMINATIONS OR CONSULTATIONS NOT ALREADY MENTIONED ☐ YES ☐ NO

CONSULTED A PHYSICIAN, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER PRACTITIONER FOR ANY REASON NOT MENTIONED ABOVE ☐ YES ☐ NO

IF THE ANSWER IS YES TO ANY OF THE ABOVE, PROVIDE A BRIEF EXPLANATION. INCLUDE NAME AND ADDRESS OF THE DOCTOR(S) AND HOSPITAL(S)

PLEASE LIST (DESCRIBE) ANY OTHER DISABILITY(IES) NOT LISTED ABOVE SUCH AS ADHD, LEARNING PROBLEMS, LEARNING DISABILITY, DYSLEXIA, ETC.

REVIEWED MEDICAL INFORMATION WITH CLIENT: DATE _____ COUNSELOR'S INITIALS _____

TO HELP US PROCESS YOUR APPLICATION FOR SERVICES, PLEASE PROVIDE YOUR COUNSELOR WITH COPIES OF ANY HEALTH INFORMATION THAT YOU MAY HAVE IN YOUR POSSESSION.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE (IF UNDER THE AGE OF 18, PARENT OR GUARDIAN MUST SIGN)	DATE	PARENT OR GUARDIAN SIGNATURE	DATE