N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
**DIVISION OF SERVICES FOR THE BLIND**
**INDEPENDENT LIVING REHABILITATION**

# HEALTH CHECK LIST INSTRUCTIONS

## PURPOSE

To gather information to determine if there appears to be a physical or mental impairment that constitutes a substantial impediment to employment that, without Vocational Rehabilitation (VR) Services or Independent Living Rehabilitation (ILR) Services, would prevent the individual from fully participating in a VR/ILR Program.

## PREPARED BY

Vocational Rehabilitation/Independent Living Rehabilitation Counselor

## INSTRUCTIONS

**Name**: Enter the individual's name (first name, middle initial and last name).

**Date**: Enter the two-digit month, two-digit day and four-digit year of the current date.

**Age**: Enter the individual's two-digit age.

**Height**: Enter the individual's height in feet and inches (example: 5'3" or 11'2").

**Weight**: Enter the individual's current two-digit or three-digit weight.

**A. Do you currently have difficulty with**: Place an X in the appropriate blocks using the individual's statements, medical information, eye reports and mental health information.

**B. Have you ever had, or been told that you have, problems with any of the following**: Place an X in the appropriate blocks using the individual's statements, medical information, eye reports and mental health information.

**C. Have you ever been treated for problems with**: Place an X in the appropriate blocks. List other drugs identified by the individual's statements, medical information, eye reports and mental health information.

**D. Have you been treated for any injuries or conditions**: Enter each injury/condition/surgery in the left column and any current limitations in the right column using individual's statements, medical information, eye reports and mental health information.

**E. Are you currently taking any medications**: Enter all medications to include prescription, non-prescription and over the counter drugs to include dosage of each and purpose using the individual's statements, medical information, eye reports and mental health information.

**F. Do you use a cane**: Place an X in the appropriate blocks.

**G. Names of physicians, clinics & therapists most familiar with your health:** Enter names of physicians, clinics & therapists to include address and date of treatments using the individual's statements, medical information, eye reports and mental health information.

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**H. Hospitals, treatment or Rehabilitation Programs where you were an in-patient**: Enter all hospitals, treatment and rehabilitation programs to include dates, names and addresses using the individual's statements, medical information, eye reports and mental health information.

**I. Please summarize the most important problem that interferes with your usual type of work and/ or activities of daily living. How long have you been bothered and is the problem getting worse or better**: Summarize briefly the most important problems that interfere with the individual's usual type of work or Independent living skills using the individual's statements, medical information, eye reports and mental health information.

**J. Do you have**: Place an X in the appropriate blocks.

VR/ILR Counselor signs and dates the form.

Applicant signs and dates the form.

**DISTRIBUTION**

Original: Case Record