Ohio | Opportunities for Ohioans with Disabilities

HEALTH ASSESSMENT QUESTIONNAIRE

PART I. IDENTIFICATION INFORMATION		
Last Name	First Name	M.I.
What is / are your disability(ies)?		
Are you **currently** receiving treatment for your disability(ies) and / or any other physical or mental problem(s)? ☐ No ☐ Yes If **YES**, provide a brief description:		
Please list any medications you are **currently** taking:		

PART II. TREATING SOURCE INFORMATION			
PRIMARY CARE PHYSICIAN (PCP)			
Name of Doctor		Date of Last Visit	
Address		Reason(s)	
Date(s) of Treatment	Telephone		
LIST ALL MEDICAL PROFESSIONALS FAMILIAR WITH YOUR DISABILITY(IES), OTHER THAN THE PCP			
Name of Doctor(s)		Name of Doctor(s)	
Address		Address	
Date(s) of Treatment	Telephone	Date(s) 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	
Date(s) of Treatment		Date(s) of Treatment	

(ATTACH ADDITIONAL SHEETS IF NEEDED)

PART III. REPORTED MEDICAL HISTORY

DURING THE **PAST TWO (2) YEARS**, HAVE YOU **RECEIVED TREATMENT** FOR ANY OF THE FOLLOWING AREAS?

A. **ENT: e**yes, ears, nose, throat, hearing impairments ☐ YES ☐ NO

B. **Neurological:** frequent headaches, dizziness, stroke, epilepsy, seizure disorder, traumatic brain injury, cerebral palsy, paralysis ☐ 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, gallbladder, liver, kidney, bladder, prostate, genitourinary ☐ YES ☐ NO

F. **Endocrine:** diabetes, thyroid ☐ YES ☐ NO

G. **Orthopedic:** neuritis, arthritis, gout, amputation, 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, schizophrenia, bipolar, ADHD or other emotional disorder ☐ YES ☐ NO

J. **Cognitive:** developmental, learning, autism spectrum disorders ☐ YES ☐ NO

K. **Vision Impairments:** diabetic retinopathy, cataracts, glaucoma, retinitis ☐ YES ☐ NO

L. **Infectious Diseases:** hepatitis, tuberculosis, HIV/AIDS ☐ YES ☐ NO

M. **Substance Abuse:** alcoholism, drugs ☐ YES ☐ NO

N. **Other:** had, or been advised to have, any surgical procedures, hospitalizations, medical examinations or consultations not already mentioned ☐ YES ☐ NO

Has a physician, psychiatrist, psychologist or other practitioner been consulted for any reason not mentioned above? ☐ YES ☐ NO

If the answer is **YES** to any of the above, have any condition(s) affected work (e.g. missed/late for work, job performance issues)?

Please list (describe) any other disability(ies) not listed above(such as spina bifida, sickle cell, anemia, dyslexia, etc) and if the condition(s) affected work:.

PART IV. FUNCTIONAL LIMITATION INFORMATION

In your own words, how does / has your disability(ies) interfere with you getting or holding a job?

How does / has your disability(ies) affect the following work activities?
(Check all boxes that apply and provide a brief explanation)

Physical limitations: ☐ Talking ☐ Hearing ☐ Seeing ☐ Bending	☐ Standing/Walking ☐ Lifting/Carrying/Grasping ☐ Stamina ☐ Transportation ☐ Other
Cognitive limitations: ☐ Reading/Writing ☐ Memory ☐ Following instructions	☐ Keeping focused/Concentration ☐ Problem solving ☐ Organizing/Prioritizing ☐ Other
Emotional/Behavioral limitations: ☐ Getting started/Staying motivated ☐ Handling stress ☐ Adapting to change ☐ Controlling frustration/Anger	☐ Getting along with others ☐ Being on time ☐ Work done on time ☐ Other
Environmental limitations: ☐ Inside ☐ Heat ☐ Chemical ☐ Heights	☐ Outside ☐ Cold ☐ Noise ☐ Other
Self-Care/Independence limitations: ☐ Grooming/Bathing ☐ Transportation	☐ Dressing ☐ Other

Any other additional functional limitation information not listed above: