HEALTH ASSESSMENT RECORD

Name: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

Date of Birth: _____ Current Age: _____ Sex: ☐ Male ☐ Female ☐ Other

Future Job Title: _____ Employer: _____

PRESENT MEDICAL HISTORY:

Current Physician: _____ Location: _____

List all medications being taken (include over the counter, birth control, vitamins, etc.)

_____

Do you have a medical marijuana card? ☐ Yes ☐ No

			If yes, explain:
Are you being treated for any medical condition now?	☐ Yes	☐ No	_____
Do you smoke? _____packs/day for _____years	☐ Yes	☐ No	_____

If you quit, when? _____

ALLERGIES:

Are you allergic to or had a bad reaction to any medicines?	☐ Yes	☐ No	_____
Have you had a reaction to latex, food, chemicals or anything in the environment (air)?	☐ Yes	☐ No	_____

SURGERY HISTORY:

Have you ever had any surgery (hospital, stay one day stay, ambulatory surgery center, child birth, etc.)?	☐ Yes	☐ No	_____

MEDICAL HISTORY:

Have you ever had any medical condition which required you to be in a hospital?	☐ Yes	☐ No	_____
Have you ever been rejected from employment or military for reasons of health?	☐ Yes	☐ No	_____

Have you had a Worker's Compensation injury? ☐ Yes ☐ No _____

Have you ever received Worker's Compensation or rating for permanent impairment? ☐ Yes ☐ No _____

Have you ever had physical therapy? ☐ Yes ☐ No _____

Have you had chiropractic therapy? ☐ Yes ☐ No _____

Have you ever had an MRI or CT scan for you neck, back or extremity? ☐ Yes ☐ No _____

REVIEW OF SYSTEMS:

Have you had or do you now have any of the following illnesses, injuries, or recurring symptoms?

HEAD:			**If yes, explain:**
Head injuries	☐ Yes	☐ No	_____
Headaches	☐ Yes	☐ No	_____
Epilepsy/Seizures	☐ Yes	☐ No	_____
Eye/Ear/Nose/Throat Problems	☐ Yes	☐ No	_____
CHEST			
Recurrent Lung Problems (i.e. asthma, bronchitis	☐ Yes	☐ No	_____
Shortness of Breath	☐ Yes	☐ No	_____
Chest pain/Heart Attack	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Heart Thumping (palpitations)	☐ Yes	☐ No	_____
Heart Murmur	☐ Yes	☐ No	_____
ABDOMEN			
Stomach Ulcers	☐ Yes	☐ No	_____
Gall Bladder Problems	☐ Yes	☐ No	_____
Intestinal Problems	☐ Yes	☐ No	_____
Hernia	☐ Yes	☐ No	_____
Hepatitis or other chronic infections	☐ Yes	☐ No	_____
URINARY / GENITAL			
Kidney/Bladder Trouble	☐ Yes	☐ No	_____
Gynecological Problems (if female) that may affect work	☐ Yes	☐ No	_____

Testicular Problems (if male) that may affect work	☐ Yes	☐ No	_____
MUSCULOSKELETAL			
Neck Injuries (strain, whiplash, surgery)	☐ Yes	☐ No	_____
Back Injury (strain, sprain, surgery)	☐ Yes	☐ No	_____
Disc Problems in Neck or Back	☐ Yes	☐ No	_____
Pinched Nerve	☐ Yes	☐ No	_____
Shoulder, Elbow, Wrist, Hand Injury, (broken bone, Sprain)	☐ Yes	☐ No	_____
Hip, Knee, Ankle, Foot Injury	☐ Yes	☐ No	_____
Arthritis/Bursitis/Tendonitis	☐ Yes	☐ No	_____
Repetitive Strain/Overuse Injury	☐ Yes	☐ No	_____
Carpal Tunnel Syndrome	☐ Yes	☐ No	_____
Other	☐ Yes	☐ No	_____
BLOOD			
Anemia/Bleeding Problem	☐ Yes	☐ No	_____
Sickle Cell Disease/Trait	☐ Yes	☐ No	_____
Blood Thinners	☐ Yes	☐ No	_____
ENDOCRINE			
Diabetes (sugar problems, insulin, pills)	☐ Yes	☐ No	_____
Thyroid or Parathyroid	☐ Yes	☐ No	_____
BEHAVIOR/MENTAL HEALTH- DEPENDENCE			
Had a drinking problem or drug dependency	☐ Yes	☐ No	_____
Treatment for alcohol or drugs	☐ Yes	☐ No	_____
Difficulty due to nerves or emotions	☐ Yes	☐ No	_____
History of treatment for psychiatric problems	☐ Yes	☐ No	_____
Taking any medications for anxiety or other psychological conditions	☐ Yes	☐ No	_____
SKIN			
Rash/Psoriasis/Eczema	☐ Yes	☐ No	_____
Allergic Reactions	☐ Yes	☐ No	_____
Lumps and/or Growths	☐ Yes	☐ No	_____

OTHER

Do you have any medical or physical condition ☐ Yes ☐ No _____

not mentioned above?

IMMUNIZATIONS

If you are not a healthcare worker, please skip this section. Go to "Previous Occupational History Section."

NOTE: Bring with you any immunization records and any titer results for Measles, Mumps, Rubella, Varicella (chicken pox, Hepatitis B, Tdap (tetanus, diphtheria, pertussis), and influenza. Also being records of skin testing or blood testing for tuberculosis.

PREVIOUS OCCUPATIONAL HISTORY

Please list previous employers, your job title and a brief job descriptions (list most recent position first)

DATES FROM	TO	COMPANY NAME	JOB TITLE	JOB DESCRIPTION
1.				
2.				
3.				

CHEMICAL EXPOSURE

List any chemicals you are sensitive to:

Have you ever worked with or been exposed at work to any of the following?		
Coal or wood dust	☐ YES	☐ NO
Nickle or Chromium	☐ YES	☐ NO
Silica (foundry or sand blasting)	☐ YES	☐ NO
Arsenic or Asbestos	☐ YES	☐ NO
Organic Solvent	☐ YES	☐ NO
Lead	☐ YES	☐ NO
Cadmium (used in battery manufacturing)	☐ YES	☐ NO
Other	☐ YES	☐ NO
Have you ever had blood tests for any of the above chemicals? If yes, explain:	☐ YES	☐ NO

I have read this form and all of the information completed on this Health Assessment Record is correct and try to the best of my knowledge that the information if provided is complete and true.

_____ _____

Patient Signature Date

Health Assessment Record

PHYSICAL EXAMINATION PERFORMED BY A CLINICIAN

Vitals:

Height (inches) _____ Weight _____ BMI_____

Blood Pressure _____/_____ Pulse_____ Temp_____ 02sat_____

Back Assessment: _____ Lbs. lifted

Whisper Test: Pass_____ Failed_____

Vision Exam:

Uncorrected: Right Eye 20/___ Left Eye 20/___ Both 20/___

Corrected: Right Eye 20/___ Left Eye 20/___ Both 20/___

Color: Pass_____ Failed_____ Comments:

Peripheral Test (only for 7D): Right_____ Left_____ Comments:

U/A Dipstick (only if required):

Blood _____ Ketone _____ Glucose _____ Protein _____ pH_____

	Normal	Abnormal	Comments
General Appearance	☐	☐	_____
Eyes	☐	☐	_____
Ears	☐	☐	_____
Nose/Sinuses	☐	☐	_____
Mouth	☐	☐	_____
Teeth/Gums	☐	☐	_____
Neck	☐	☐	_____
Thyroid	☐	☐	_____
Lungs	☐	☐	_____
Heart	☐	☐	_____
Abdomen			
Tenderness	☐	☐	_____
Masses or Hernias	☐	☐	_____
Lymph Nodes	☐	☐	_____
Spine			
Alignment	☐	☐	_____
Forward Flexion	☐	☐	_____
Back Extension	☐	☐	_____
Straight Leg Raise	☐	☐	_____

Extremities			
Joints/Range of Motion	☐	☐	_____
Strength	☐	☐	_____
Tinel's/Phalen at Wrist	☐	☐	_____
Neurological			
Deep Tendon Reflexes	☐	☐	_____
Tremors	☐	☐	_____
Romberg	☐	☐	_____
Skin	☐	☐	_____
Pulses	☐	☐	_____

Summary of Significant Findings:

General Recommendations:

_____

Decision pending the review of the following information:

Medically Qualified: ☐ **YES** ☐ **NO** **Respirator Cleared:** ☐ **YES** ☐ **NO** ☐ **N/A**

_____ **_____**

Provider Signature **Date**