

Family History and IN CASE OF EMERGENCY

Spouse's Name: _____	Living: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother's Name: _____	Living: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Father's Name: _____	Living: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Number of Children: _____	Age of Oldest _____	Age of Youngest _____	
Number of Brothers / Sisters _____	Age of Oldest _____	Age of Youngest _____	

Name of Local Friend or Relative in Case of Emergency	Relationship to Patient	Home Phone No	Work Phone No.
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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Rehab After Work I understand that I am financially responsible or any balance. I also authorize Rehab After Work or insurance company to release any information required to process my claims.

X

Patient/Guardian Signature Date

Rehab After Work: Health Questionnaire

Name: _____

Current Treatment

Do you have any current medical problems? Please Describe	Is it being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom?		
What medication(s) are you taking? (Include over the counter medication) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Drug</td> <td style="width: 50%; border: none;">Dose/Frequency</td> </tr> </table>	Drug	Dose/Frequency	Who is your Primary Care Physician? Name: _____ Phone or Location: _____ Have you ever had a drug allergy or sensitivity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to which drug(s)? _____
Drug	Dose/Frequency		
When was your last physical exam?	What is your height? Weight		

Family Medical History

Have any of your blood relatives suffered from the following disease(s) or problem(s)?

	Please Check		Which relative(s)?
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes (Sugar)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
TB (Tuberculosis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Nervous/Emotional Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other (specify)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Name: _____

Personal Medical History

Do you have or have you ever had any of the following health problems? (Check Yes or No)

High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer/Gastritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Head Injuries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice/Liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually Transmitted Disease Syphilis, Gonorrhea, Chlamydra, NGU	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid/Endocrine	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Personal Health Screen

Do you have now, or have you ever had any of the following symptoms? (Check Yes or No)

Poor appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Trouble with vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Earaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
No energy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent sore throats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain or tightness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin rash, sores or lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle or joint problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abdominal pain/swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convulsions (fits)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Black stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Painful urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No

DO NOT WRITE BELOW THIS LINE

Counselor _____

Date _____

Refer to Primary Care Physician

Name: _____

TB / HIV/ AIDS RISK ASSESSMENT

TUBERCULOSIS (TB) RISK ASSESSMENT

Have you ever had a positive skin test for tuberculosis (TB)? Yes No

Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks?

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drenching night sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Productive cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing up blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lumps or swollen glands in the neck or armpits	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea (runs) lasting more than a week	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you live or have you had close contact with a person who has tuberculosis? Yes No

Do you know someone who has the following symptoms? (Check Yes or No)

Coughing up blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drenching night sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered “yes” to three or more of the above questions, you are considered at High Risk for Tuberculosis.

DO NOT COMPLETE THIS BOX – FOR EMPLOYEES ONLY

Client was referred to a physician or the Department of Health for being at risk for TB:

Yes No

HIV / AIDS RISK ASSESSMENT

Have you engaged in any high risk behaviors which would put you at risk for HIV/AIDS including:

Unprotected sex:

Yes No

Multiple partners:

Yes No

History of STD:

Yes No

*Sharing of
Needles:*

Yes No

If you answered “yes” to two or more of the above questions, you are considered at High Risk for HIV/AIDS.

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Client was referred to a physician or the Department of Health for being at risk for HIV/AIDS and to seek Pre-Test / Post-Test Counseling: Yes No
