

Rehab After Work Biographical Data

All information is strictly confidential – Rehab After Work will not release
This information or contact anyone listed below without your written consent.

Do you prefer your treatment to be conducted during the: day or evening.

IDENTIFICATION DATA

1. Name: Last First MI			2. Age:	3. Birthdate	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
5. Mailing Address: PO Box or Street City State Zip				6. Home Phone	7. Work Phone
8. Marital Status: <input type="checkbox"/> 1. Married <input type="checkbox"/> 2. Never Married <input type="checkbox"/> 3. Divorced <input type="checkbox"/> 4. Separated <input type="checkbox"/> 5. Living together <input type="checkbox"/> 6. Widowed <input type="checkbox"/> 7. Divorced, remarried <input type="checkbox"/> 8. Divorced, living together				9. Religion	
10. Education: Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 <input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> Some college <input type="checkbox"/> BS/BA <input type="checkbox"/> Some Graduate <input type="checkbox"/> MS/MA <input type="checkbox"/> PhD				11. Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Race: <input type="checkbox"/> 1. African-American <input type="checkbox"/> 2. Hispanic <input type="checkbox"/> 3. Native American <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. White <input type="checkbox"/> 6. Other (specify) _____		13. Income: <input type="checkbox"/> 1. \$0-5,000 5. <input type="checkbox"/> \$20,001-25,000 <input type="checkbox"/> 2. \$5,001-10,000 6. <input type="checkbox"/> \$25,001-50,000 <input type="checkbox"/> 3. \$10,001-15,000 7. <input type="checkbox"/> \$50,001-75,000 <input type="checkbox"/> 4. \$15,001-20,000 8. <input type="checkbox"/> \$75,000+			

FAMILY HISTORY

Family Members	Age	Living		Occupation
		Yes	No	
14. Spouse's Name				
15. Mother's Name				
16. Father's Name				
17. Number of children of person completing form		Age of Oldest	Age of Youngest	Number Living ____ Deceased ____
18. Number of brothers and/or sisters of person completing form:		Age of Oldest	Age of Youngest	Number Living ____ Deceased ____
19. Who can we notify in case of emergency or other need to reach you?	Address:		Home Phone	
Name _____	Relation to you: _____			

REFERRAL INFORMATION

20. Who referred you to Rehab After Work? (Check all that apply)	
<input type="checkbox"/> Self	<input type="checkbox"/> Mental Health Professional
<input type="checkbox"/> Family/Relative	<input type="checkbox"/> Employee Advisor Program
<input type="checkbox"/> Friend	<input type="checkbox"/> Primary Care Physician (PCP)
<input type="checkbox"/> Advertisement Brochure (Specify)	<input type="checkbox"/> Other (Specify) _____

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: 30%; text-align: center;">Drug</td> <td style="width: 70%; text-align: center;">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)?

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid/Endocrine	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Personal Health Screen

Have you recently lived in: (Check all that apply)

Shelter On the street/homeless A jail A crack house

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

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle or joint	<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	<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

Name: _____

DO NOT WRITE BELOW THIS LINE

This section to be completed by practice Staff

Counselor

Date

Consulting Psychiatrist

Date

Refer to Primary Care Physician

Comments: _____