The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)

Confidential Health Assessment

VR-26 (6/15)

This form gathers information on your general health. The information is important and will help us in the eligibility and vocational planning process. This information is confidential and will not be shared outside of ACCES-VR without your permission.

NAME: *Last*	*First*	MI	DATE

MAILING ADDRESS: *Street*	*Apartment and/or Building Number*

City	State	Zip Code	DATE OF BIRTH

Would you describe your health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When was your last general physical examination? _____
date

Your doctor or clinic's name, address, and telephone number

Please check the box(es) that best describes you

Do you have any difficulty with:	No Difficulty	Some Difficulty	Cannot Do
Walking	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Using your right foot / leg	☐	☐	☐
Using your left foot / leg	☐	☐	☐
Using your right hand / arm	☐	☐	☐
Using your left hand / arm	☐	☐	☐
Reaching above your shoulders	☐	☐	☐
Moving your fingers	☐	☐	☐
Hearing	☐	☐	☐
Seeing	☐	☐	☐
Speaking	☐	☐	☐
Pushing	☐	☐	☐
Pulling	☐	☐	☐
Carrying	☐	☐	☐
Lifting	☐	☐	☐
Reading	☐	☐	☐
Doing arithmetic	☐	☐	☐
Working with people	☐	☐	☐

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Do you now have or have you had:	Yes	No		Yes	No
Intellectual Disability	☐	☐	Speech Problems	☐	☐
Vision Problems	☐	☐	Head Injury	☐	☐
Hearing Problems	☐	☐	Cerebral Palsy	☐	☐
Orthopedic Limitations	☐	☐	Multiple Sclerosis	☐	☐
Mental / Emotional Conditions	☐	☐	Muscular Dystrophy	☐	☐
Substance Use Disorders	☐	☐	Diabetes	☐	☐
Allergies / Asthma	☐	☐	Stroke	☐	☐
Heart Disease	☐	☐	Arthritis	☐	☐
Respiratory I Lung Disorder	☐	☐	Skin Disease/ Rashes	☐	☐
Ulcers, Colitis	☐	☐	Cancer	☐	☐
Kidney Disease	☐	☐	Learning Disability	☐	☐
High Blood Pressure	☐	☐	HIV Related Diseases	☐	☐
Seizure Disorder/ Epilepsy	☐	☐	Other. _____	☐	☐

if you answered "Yes to any of the above, please describe how it might affect vocational training or your ability to work.

Do you have difficulty working Where there is / are:	No Difficulty	Some Difficulty	Cannot Do		No Difficulty	Some Difficulty	Cannot do
Temperature / humidity changes	☐	☐	☐	Dust / fumes	☐	☐	☐
Unprotected heights	☐	☐	☐	Loud noises	☐	☐	☐
Moving machinery	☐	☐	☐	High stress	☐	☐	☐
Other situations: _____					☐	☐	☐

Can you work full time? ☐ Yes ☐ No

If you answered **"No",** how many hours a day do you feel you can work? _____ hours

Do you need special parking? ☐ Yes ☐ No

What special accommodations do you need? ☐ wheelchair ☐ hearing aid ☐ cane / walker ☐ TTY ☐ attendant ☐ interpreter ☐ others

Do you have any other physical or mental condition which might affect vocational training or your ability to work? If so, please explain.

Are you currently taking any medication? if so, please explain.

I certify, by my signature below, that this information is complete and true to the best of my knowledge.

_____ _____

Signature *Completed by*

Please feel free to attach additional *explanation(s)*