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A6.0 ANNUAL HEALTH ASSESSMENT

PATIENT NAME: _____ **DOB:** _____ **DATE OF EXAM:** _____

1. Are you being treated for any health problems? Yes ____ No ____
   If yes, please explain: _____
2. Are you taking any medication regularly at this time? Yes ____ No ____
   If yes, what kind and why: _____
3. Have you had any injuries/illnesses during the past year? Yes ____ No ____
   If yes, please explain: _____
4. Have you had any hospitalizations and/or surgery during the past year? Yes ___No ___
   If yes please explain: _____
5. Are you addicted to depressants, stimulants, narcotics, alcohol or any other drug or substance that may alter behavior or impair the performance of your duties?
   Yes ____ No ____
6. Do you have any allergies? Yes ___ No ___
   If yes, to what: _____

Indicate by a check if you have experienced and/or been treated for any of the following:

Rheumatic Fever ____ Diabetes ____ Asthma ____ Dermatitis ____ Heart Disease ____
Seizures ____ Fainting ____ Bleeding Problems ____ Angina ____ Shortness of Breath ____
High Blood Pressure ____ Menstrual Problems ____ Tuberculosis ____ Headaches ____

I certify to the best of my knowledge that I am free from any health impairment that may be of potential risk to the patient or may interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter my behavior. I also certify that the information on this form is accurate.

_____
Patient Signature

TO BE COMPLETED BY HEALTHCARE PROVIDER:

RUBELLA	**RUBEOLA**
Date of Immunization:_____	Date of Immunization:_____
Numeric Titer Level:_____(required)	Numeric Titer Level:_____(required)

PPD

Date Given:	Date Read:	Results : Level:
Chest X-Ray (if positive PPD)	Date:	

On the basis of my examination and the information above, I find the above person fit to give adequate care at this time and is free from all communicable disease.

Healthcare Providers Name (Print) _____License #._____
(Clinical Supervisor if NP or PA)

Address: _____

Provider's Signature: _____ Date:_____

** **New York State Department of Health requires each therapist to have an annual health assessment**. **
(Please complete this form with the help of your Health Care Provider)