DRIVER REHAB PROGRAM INTAKE FORM
Please complete this form & bring it with you when you come for your appointment

Patient's Name: _____ Today's Date: _____
Date of Evaluation: _____

PERSONAL/SOCIAL HISTORY:

Marital Status: Married____ Single____ Divorced____ Separated____ Widowed____

Living Situation: Lives alone____ With spouse/significant other____ With child(ren)____
Other_____

Work / Volunteer history: Works full time____ Works Part time____ Retired_____
Volunteers____ Other _____

Currently employed with _____as_____

Plan to return to work? YES or NO

Drives for work? YES or NO Explain_____

Leisure activities: (What activities do you participate in for fun?)
Present: _____
_____

Educational Background:
Highest grade completed: High School Diploma____ College Grad____ GED____ Other: _____

DAILY LIVING SKILLS HISTORY

Self-care (bathing, dressing, feeding, etc.): ____Independent ____Needs assistance ____Unable comments:
_____

Homemaking (cooking, cleaning, laundry, etc.): ____Independent ____Needs assistance ____Unable comments:
_____

Do you use any adaptive equipment? (ex: grab bars, bedside commode, reachers, etc.):
_____

What do you have the most difficulty doing for yourself? _____

Able to read: ____YES ____ NO ____With difficulty
Able to write: ____YES____ NO ____With difficulty
Memory problems: ____YES ____ NO If YES explain: _____

DRIVING HISTORY:

____ Valid Driver's License ____Valid permit _____License suspended & date
License/permit number: _____ Expiration date: _____
Prior license restrictions: _____
Driving experience: ____Highway ____Local ____Long Distance ____Night
Date last drove: _____
Driving needs: (Example: to go to MD appts, shopping/errands): _____
_____
Current means of transportation: _____
Does the MVA know about your current Medical Condition: ____YES ____NO
Name of Case Manager at the MVA: _____

Type of vehicle: (Make and year)
____ Automatic transmission
____ Power steering ____ Power brakes Airbags ___ Front ___ Side
____ Standard 4-5 speed clutch
____ 2 door ____ 4 door
____ Truck ____ Van ____ with lift ____ without lift ____ Other:

Medical History

Do you have or have ever had any of the following medical problems:

	YES	NO	Date Started (year)	Comments
Alcohol Use				Frequency:
Anemia				
Anxiety				
Arrhythmia/ Irregular Heart Beat				
Arthritis				Where:
Back or Neck Problems (list)				
CAD (coronary artery disease)				
Cancer (what kind)				
Carpal Tunnel Syndrome				Right? Left?
CHF (Congestive heart failure)				
Concussion/ Head Injury				
COPD/ Asthma/ Emphysema				
Depression/ Other mental health				
Diabetes				Neuropathy?
DVT/PE – Blood Clot (circle)				
Fracture/ Broken Bone				
GERD/ Reflux				
Gout				
Heart Attack(MI)				
High Blood Pressure				
Hyperthyroid (overactive)				
Hypothyroid (underactive)				

Medical History *continued…*

	YES	NO	Date Started (year)	Comments
Osteoporosis				
MS (Multiple Sclerosis)				
Parkinson's Disease				
PVD/ Vascular Disease				
Renal/ Kidney Problems				
Seizures				Date of Last Seizure:
Stroke				
Tobacco Use				Frequency:
Tuberculosis				
Vision/ Hearing (list)				Date of last Vision Exam: Wears glasses: YES ____ NO ____ Reason: Hearing Aids: __L __R __Both
Women's Health Issues (list)				
Surgery				
Back or Neck				
Knee Replacement				
Hip Replacement				
CABG (heart Bypass)				
Pacemaker or AICD				
C- section				
Hysterectomy				
Vision				
Other Medical or Surgical History				
Allergies: to Meds, Seasonal, Environmental				
Are you medically Disabled?				

Name of Medication	Dosage	How Often	Date Started	Comments