CONSUMER DIRECT CARE NETWORK

EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

Background: At this point in the employment process, you have been conditionally hired by a Consumer/Member/ Representative/Individual ("Employer") as an Employee. Your position involves delivering services for the Employer. Your duties will vary according to the needs and authorized services of the Employer, but will require you to perform tasks of a physical nature, which have physical demand requirements. The purpose of this Health Questionnaire is to obtain information about your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

Instructions: Respond to each item as to whether you have a medical or physical activity restriction or limitation to physical activity. **Please explain each "Yes" answer on the reverse of this form and attach additional information as necessary.**

Return this completed form, with the other employment forms, to the Consumer Direct Care Network (CDCN) office.

	Do you currently have a Physical Activity Restriction for:	**NO**	**YES**
1	Sitting		
2	Stationary Standing		
3	Walking		
4	Ability to be Mobile		
5	Crouching (bending at knee)		
6	Kneeling/Crawling		
7	Stooping (bending at waist)		
8	Twisting (knees/waist/neck)		
9	Turning/Pivoting		
10	Climbing		
11	Balancing		
12	Reaching overhead		
13	Reaching extension		
14	Grasping		
15	Pushing/Pulling		
16	Lifting/Carrying		
17	Whole/Partial Loss of Hearing		
18	Blindness (partial or complete) or Eye Problems		
19	Have you ever been advised by a health care professional to restrict your physical activities in any way?		
	Personal Medical History **In the past 5 years, have you had or been treated for:**	**NO**	**YES**
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back Injury		
25	Ruptured Intervertebral Disc		
26	Joint Injury or Pain		
27	Fractures		
28	Tuberculosis or Non-Negative TB Test		
29	Lung Problems/Disease		
30	Head Injury		
31	Other Current Problems, Diseases, Conditions		
32	Have you been hospitalized or undergone surgery, other than for childbirth?		
33	Have you refused a recommended surgical procedure?		
34	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		

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Employee Name: _____
(please print)

Do you currently have, or have you ever been told by a health care professional that you have, any physical limitations in reference to the list below?							
		NO	**YES**			**NO**	**YES**
A	Back			H	Arm		
B	Shoulder			I	Hip		
C	Neck			J	Knee		
D	Elbow			K	Ankle		
E	Wrist			L	Foot		
F	Hand			M	Leg		
G	Finger			N	Other		

CDCN does not discriminate in hiring, promotion, or other terms and conditions of employment and does not discriminate against persons who have, in good faith, filed a claim for or received benefits pursuant to State Workers' Compensation Laws. Requests for Accommodations which allow employees to perform the essential functions should be requested in writing and will be provided if they do not cause an undue hardship.

Please explain any "Yes" answers from page 1 and 2 in detail below and note the associated number or letter. Also, include the dates of injuries & surgeries. Use additional pages if necessary:

_____

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_____

I hereby certify that I have answered the above questions to the best of my knowledge, and that my answers are true and complete. I understand that misrepresentation or omission of facts is cause for dismissal and may result in denial of workers' compensation benefits.

Employee Signature: _____ Date: _____/_____/_____

Office Use Only

Reviewed by: [_____] Date _____/_____/_____ Date sent to Risk Mgr: _____/_____/_____

State Office/Location: _____ Risk Mgr Review: [_____] Date _____/_____/_____

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