



**the**  
**Chickasaw Nation**  
**Division of Education**  
**Vocational Rehabilitation Program**

**Bill Anoatubby**  
**Governor**

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**GENERAL HEALTH CHECKLIST**

<b>Consumer name:</b>		<b>Case number:</b>	
<b>County:</b>		<b>Counselor:</b>	

<b>Do you have: Please check the specific condition listed that applies.</b>	<b>Yes</b>	<b>No</b>	<b>Has this condition adversely affected your job performance?</b>
<b>A disorder of the eyes, ears, nose or throat</b>			
<b>Frequent fainting, dizziness or headaches</b>			
<b>Seizures, convulsions, paralysis or stroke</b>			
<b>A mental or nervous disorder</b>			
<b>Persistent coughing, bronchitis, asthma, emphysema, tuberculosis or other disorder of the lungs</b>			
<b>Chest pain, high blood pressure, rheumatic fever, murmur, heart attack or other disorder of the heart or blood vessels</b>			
<b>Intestinal bleeding, ulcer, hernia, colitis, other disorder of the intestines, liver or gallbladder</b>			
<b>Disorder of kidney, bladder, prostate or reproductive system</b>			
<b>Diabetes, thyroid or other endocrine disorders</b>			
<b>Arthritis or other disorder of the muscles or bones, including the spine, back or joints</b>			
<b>Absence or amputation of any body part</b>			
<b>Loss of use of arms or legs or other body parts</b>			
<b>A tumor, cancer or disorder of skin or lymph glands</b>			
<b>Allergies</b>			
<b>Anemia or other disorder of the blood</b>			
<b>Excessive use of alcohol or other habit forming drugs</b>			
<b>Other physical or mental condition (specify)</b>			

**General Checklist – Cntd.**

<b>Consumer name:</b>		<b>Case number:</b>	
<b>County:</b>		<b>Counselor:</b>	

**Name/address/phone number of your primary medical provider:**


**Have you been or are you being treated for any medical condition listed? If yes, by whom (provider's name and address)? When? If no, why have you chosen not to seek treatment?**


**Are you currently taking any medications?**

<b>Name of medication</b>	<b>Condition medication treats</b>	<b>Side effects of medication</b>

**Obstacles or impediments medical conditions create for consumer to attaining/maintaining suitable employment:**


**Additional remarks:**


**Consumer's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Counselor's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_