Name: ____________________________
Date of Birth: _____________________

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 NO
Drives for work? YES 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 ____ explain:__________________________________

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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 you 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				

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MEDICAL HISTORY (continued)

	Yes	No	Date started (year):	Comments
GERD/Reflux				
Gout				
Heart Attack (MI)				
High Blood Pressure				
Hyperthyroid (overactive)				
Hypothyroid (underactive)				
Osteoporosis				
MS (multiple sclerosis)				
Parkinson’s Disease				
PVD/Vascular Disease				
Renal/Kidney problems				
Seizures				If Yes, 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	**Yes**	**No**	**When (year)**	**Comments**
Back or Neck Surgery				
Knee Replacement				
Hip Replacement				
CABG (heart bypass)				
Pacemaker or AICD (circle)				
C-section				
Hysterectomy				
Vision (ie; cataracts)				Type of surgery:
OTHER Medical or Surgical history not listed:				
Allergies: To meds, seasonal, environmental				
Are you medically Disabled?				

Name: ___________________________
Date of Birth: _________________

Driver Rehab Program
Medication List **page 4 of 4**

Today's Date: _____________________

Name of Medication	Dosage	How often	Date Started	Comments

Person completing this form: ☐ Patient ☐Caregiver ☐Other _______________________________
Therapist Signature: ____
Date/Time: ________________
Printed Name: ____