

New Beginnings Home Care, Inc.

Annual Employee Assessment

This questionnaire is for the purpose of obtaining a complete health profile and to comply with the American with Disabilities Act. Further, the information will allow New Beginnings Home Care to evaluate and provide reasonable accommodations for any qualifying disability you may have. This information will be kept confidential in a separate medical file, apart from your personnel file.

IMPORTANT: Any employee who falsely represents their condition(s) in writing at the time of entering into the employment relationship with New Beginnings Home Care may be denied Worker's Compensation benefits; in addition, any false representation at this time may subject the employee to termination.

CURRENT DATE: _____

NAME _____ SS# _____ DOB _____
 ADDRESS _____ CITY/STATE/ZIP _____
 PHONE # _____ POSITION _____
 EMERGENCY CONTACT _____ PHONE# _____ RELATIONSHIP _____

INSTRUCTIONS: Circle "Y" for YES and "N" to the following questions and give dates for any yes answers. Do not skip any questions. Have you ever had or been treated for any of the following conditions or diseases:

			Date				Date
1.	Severe headaches	Y	N	31.	Alcoholism/Drug addiction	Y	N
2.	Dizziness or fainting spells	Y	N	32.	Nervous breakdown, mental illness, psychiatric treatment	Y	N
3.	Seizures	Y	N	33.	Arthritis/Rheumatism	Y	N
4.	Epilepsy	Y	N	34.	Backaches	Y	N
5.	Anemia/Hemophilia/other	Y	N	35.	Head injury	Y	N
6.	Rheumatic Fever	Y	N	36.	Neck or back injury	Y	N
7.	Diabetes	Y	N	37.	Leg/knee/hip/ankle injury	Y	N
8.	Hypoglycemia (low blood sugar)	Y	N	38.	Elbow/shoulder/wrist/arm/hand injury	Y	N
9.	Cardiac Disease	Y	N	39.	Repetitive strain	Y	N
10.	High blood pressure	Y	N	40.	Arthroscopy of a joint	Y	N
11.	Varicose veins or leg ulcers	Y	N	41.	Herniated (slipped) disc	Y	N
12.	Thrombophlebitis (inflammation of vein/blood clot)	Y	N	42.	Surgical removal of a disc or a spinal fusion	Y	N
13.	Thyroid	Y	N	43.	Knee surgery	Y	N
14.	Hay fever/Asthma/Respiratory disorders	Y	N	44.	Any fracture or broken bones	Y	N
15.	Chronic cough	Y	N	45.	Any other orthopedic surgery	Y	N
16.	Shortness of breath	Y	N	46.	Amputation of a body part	Y	N
17.	Chest pain	Y	N	47.	Chronic osteomyelitis (bone infection)	Y	N
18.	Bloody sputum	Y	N	48.	Osteoporosis	Y	N
19.	Total deafness/hearing loss/ear problems	Y	N	49.	Residual disability from polio	Y	N
20.	Mental retardation/learning disability	Y	N	50.	Muscular dystrophy	Y	N
21.	Eye/vision conditions	Y	N	51.	Cerebral palsy	Y	N
22.	Hernia (rupture)	Y	N	52.	Multiple sclerosis	Y	N
23.	Ulcers	Y	N	53.	Ankylosing spondylitis	Y	N
24.	Kidney or bladder trouble	Y	N	54.	Ever have chiropractic treatment(s)	Y	N
25.	Hepatitis/liver disease	Y	N	55.	Complications of pregnancy	Y	N
26.	Parkinson's disease	Y	N	56.	Disorders of immune system (answer is optional)	Y	N
27.	Skin trouble	Y	N	57.	Any questions you don't understand. If so, what numbers?		
28.	Positive PPD (TB skin test)	Y	N				
29.	Tuberculosis	Y	N				
30.	Increased fatigue, night sweats	Y	N				

ADDITIONAL COMMENTS _____

This assessment has been reviewed by an RN. Based on these answers this individual appears to be free from any health impairment which is of potential risk to patients or which might interfere with the performance of their duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter their behavior

 RN Date _____

 Date _____
 Signature of Employee