|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Texas Workforce Solutions logo | | | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **General Physical Examination Report** | | | | | | | | | | | | | | | | | | | | |
| The information requested is necessary to help counselors determine eligibility and/or a plan for rehabilitation services for the person named. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Return Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Return Report To (Name): | | | | | | | | | | | | | | | | | | | | | | | Telephone Number:  (   ) | | | |
| Address: | | | | | | | | | | | City: | | | | | | | | State: | | | | | | ZIP Code: | |
| **Patient Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | | | | | | | | Date of Birth: | | | |
| Social Security Number: | | | | | | | | | | | | | | | | | | | | | | | Telephone Number:  (   ) | | | |
| Reported Disability: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for Referral: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Condensed Medical History | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide a condensed medical history: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Examination | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please describe any abnormalities: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height: | | Weight: | | | | | | | | Pulse: | | | | | | | Blood Pressure: | | | | | | | | | |
| Vision (Snellen):  Right 20/       Left 20/ | | | | | | | | | | | | With glasses, if available:  Right 20/       Left 20/ | | | | | | | | | | | | | | |
| **Health Status** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please enter X to select **Yes No** | | | | | | | | | | | | | | **Comments** | | | | | | | | | | | | |
| Diabetes | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Anemia | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Headaches | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Kidney disease | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Thyroid problems | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Seizures | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Alcohol/drug abuse | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Mobility problems | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Asthma | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Physical limitations | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Heat intolerance | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| Other: | | | | | | |  | | | |  | | |  | | | | | | | | | | | | |
| **Examination:** Please enter X to select Normal or Abnormal. | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | **Normal** | | | **Abnormal** | | | | | | | **Comments** | | | | | | | | | | | | |
| Pulse | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Blood pressure | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Head-scalp | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Eyes | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Ears-nose-throat | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Dental-mouth | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Neck | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Skin | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Chest-lungs | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Heart-arteries | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Abdomen | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Hernias | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Bones-joints | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Muscular | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Neurological | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Genitourinary | | | |  | | |  | | | | | | |  | | | | | | | | | | | | |
| Laboratory | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Urine: | Dipstick urinalysis for protein, sugar, and hemoglobin is required, or more complete urinalysis with microscopic if examiner feels it is needed. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Results: Enter an X to select: | | | | | | | | | | | | Within normal limits | | | | | | | | | Abnormal | | | | |
| If Abnormal, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Blood: | Physician may do hemoglobin (or hematocrit) and serology, if indicated. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Results: Enter an X to select: | | | | | | | | | | | | Within normal limits | | | | | | | | | Abnormal | | | | |
|  | If Abnormal, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | |
| X-Ray | | | | | | | | | | | | | | | | | | | | | | | | | | |
| X-Ray: | With this general examination, chest x-rays (AP & lateral) are authorized when physician indicates need. These x-rays should be obtained if evidence of past or present TB exists, or presence of other active pulmonary disease is found during exam. Other x-ray studies require prior authorization for payment by counselor. Fees paid for these procedures may not exceed the TWC-VR fee schedules. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Results: Enter an X to select: | | | | | | | | | | | | Within normal limits | | | | | | | | | Abnormal | | | | |
| If Abnormal, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis and Impressions | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Your Opinion: Can the major disability be removed or substantially improved by medical or surgical treatment? | | | | | | | | | | | | | | | | | | | | Yes    No | | | | | | |
| If No, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Functional Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What can this person do now? Please enter X to select the appropriate checkboxes that are applicable during an 8-hour workday: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | Continuously 66% or more of the time | | | | | | | | Frequently 33-66% of the time | | | | | Occasionally Up to 33% of the time | | | | | Not at all |
| Sitting | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Standing | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Walking | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Lifting 10 or less lbs. | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Lifting 10-20 lbs. | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Lifting 20-50 lbs. | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Lifting 50-100 lbs. | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Lifting over 100 lbs. | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Bending | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Stooping, kneeling, squatting, & crouching | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Crawling | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Climbing & balancing | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| Other functional limitations | | | | | | | |  | | | | | | | |  | | | | |  | | | | |  |
| (please describe): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Working Conditions** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please enter X to select any condition(s) to be avoided: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Outdoors | | | Dry | | | | | | Marked temperature changes | | | | | | | | | | | | | | | | | |
| Indoors | | | Dusty | | | | | | | | | | | | | | | | | | | | | | | |
| High humidity | | | Other: | | | | | | | | | | | | | | | | | | | | | | | |
| **Recreational Clearance (Criss Cole Rehabilitation Center)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there any reason this individual should not participate in recreation activities, including physical conditioning?    Yes    No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, explain: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Remarks and/or Recommendations | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any other remarks or recommendations; for example, other diagnostic examinations: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **All information is treated as confidential.**  **Examinee has the legal right to see this report when the examinee requests.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Examining Physician's Name (type or print): | | | | | | | | | | | | | | | | | | Telephone Number:  (   ) | | | | | | | | |
| Physician’s Address: | | | | | City: | | | | | | | | | | State: | | | | | | | | | ZIP Code: | | |
| Examining Physician’s Signature:  **X** | | | | | | | | | | | | | | | Date of Examination: | | | | | | | | | | | |