



Impairments Checklist

MENTAL FUNCTIONING DEVELOPMENTAL

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adjustment disorder <input type="checkbox"/> Alcohol dependence <input type="checkbox"/> Attention deficit/hyperactivity disorder <input type="checkbox"/> Autism <input type="checkbox"/> Behavioral disorder (SpecEd) <input type="checkbox"/> Brain injury-cognitive dysfunction <input type="checkbox"/> Drug dependence <input type="checkbox"/> Epilepsy <input type="checkbox"/> Impulse control disorder <input type="checkbox"/> Intellectual disability, borderline <input type="checkbox"/> Intellectual disability, mild <input type="checkbox"/> Intellectual disability, moderate <input type="checkbox"/> Intellectual disability, severe & profound <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Specific learning disability <input type="checkbox"/> Specific mental disorder		
Date of Onset: _____		
Doctor/Clinic: _____		
Rx: _____		

Consumer: _____

Team Member: _____

MENTAL FUNCTIONING ADULT ONSET

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adjustment disorder <input type="checkbox"/> Alcohol dependence <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Antisocial personality disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Borderline personality disorder <input type="checkbox"/> Brain injury-cognitive dysfunction <input type="checkbox"/> Cyclothymic disorder <input type="checkbox"/> Delirium, dementia, amnesic & other cognitive disorder <input type="checkbox"/> Delusional disorder <input type="checkbox"/> Dependent personality disorder <input type="checkbox"/> Depressive disorder, major <input type="checkbox"/> Disassociate disorder <input type="checkbox"/> Drug dependence <input type="checkbox"/> Dysthymic disorder <input type="checkbox"/> Epilepsy <input type="checkbox"/> Factitious disorder <input type="checkbox"/> Mood disorder- other <input type="checkbox"/> Neurotic disorder <input type="checkbox"/> Obsessive compulsive disorder <input type="checkbox"/> Panic disorder <input type="checkbox"/> Paranoid personality disorder <input type="checkbox"/> Post-traumatic stress disorder <input type="checkbox"/> Psychotic disorder, other <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Schizoid personality disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizophreniform disorder <input type="checkbox"/> Schizotypal personality disorder <input type="checkbox"/> Sexual & gender identity disorder <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Somatoform disorder <input type="checkbox"/> Specific mental disorder		
Date of Onset: _____		
Doctor/Clinic: _____		
Rx: _____		

VOICE, SPEECH, HEARING & VESTIBULAR FUNCTIONING

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/> Deaf <input type="checkbox"/> Deaf-blind <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Meniere's disease <input type="checkbox"/> Speech impairment (Spec Ed) <input type="checkbox"/> Tinnitus Specific voice, speech, hearing or <input type="checkbox"/> vestibular disorder <input type="checkbox"/> Brain-injury-aphasia <input type="checkbox"/> Laryngectomy Stroke-aphasia Date of Onset: _____ Doctor/Clinic: _____ Rx: _____		

CARDIOVASCULAR FUNCTIONING

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/> Anemia <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Arteriosclerotic cardiovascular disease <input type="checkbox"/> Cardiac arrhythmias <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Congenital heart condition <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hypertension <input type="checkbox"/> Leukemia & aleukemia <input type="checkbox"/> Myocardial disease <input type="checkbox"/> Peripheral vascular disorder <input type="checkbox"/> Reynaud's disease <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Valvular heart disease Specific cardiovascular disorder Date of Onset: _____ Doctor/Clinic: _____ Rx: _____		

SEEING

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/> Blindness, both eyes <input type="checkbox"/> Blindness, one eye <input type="checkbox"/> Cataract <input type="checkbox"/> Visual impairment (Spec Ed) <input type="checkbox"/> Specific visual disorder Date of Onset: _____ Doctor/Clinic: _____ Rx: _____		

RESPIRATORY FUNCTIONING

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/> Asbestosis <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumoconiosis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Specific respiratory disorder Date of Onset: _____ Doctor/Clinic: _____ Rx: _____		

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DIGESTIVE, NUTRITIONAL METABOLIC FUNCTIONING

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<ul style="list-style-type: none"> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Colostomy <input type="checkbox"/> Dental disorder <input type="checkbox"/> Diverticular disorder <input type="checkbox"/> Element deficiency/toxicity disorder <input type="checkbox"/> Enteritis <input type="checkbox"/> Gastritis <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Hiatus hernia <input type="checkbox"/> Obesity <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Temporal mandibular joint disorder <input type="checkbox"/> Ulcers-stomach/duodenum <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Specific digestive, nutritional or metabolic disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Cholecystitis <p>Date of Onset: _____</p> <p>Doctor/Clinic: _____</p> <p>Rx: _____</p>		

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IMMUNOLOGICAL & ENDOCRINOLOGICAL DISORDERS

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<ul style="list-style-type: none"> <input type="checkbox"/> Acquired immune deficiency disorder (AIDS) <input type="checkbox"/> Addison's disease <input type="checkbox"/> Adrenal disorder <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Autoimmune disorder <input type="checkbox"/> Avitaminosis <input type="checkbox"/> Cushing's syndrome <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Human immune virus (HIV) <input type="checkbox"/> Hodgkin's disease <input type="checkbox"/> Hypersensitivity reactions & disorders <input type="checkbox"/> Lyme disease <input type="checkbox"/> Pituitary disorder <input type="checkbox"/> Premenstrual syndrome <input type="checkbox"/> Systemic lupus erthematosus <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Specific immunological & endocrinological disorders <p>Date of Onset: _____</p> <p>Doctor/Clinic: _____</p> <p>Rx: _____</p>		

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GENITOURINARY

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<ul style="list-style-type: none"> <input type="checkbox"/> End stage renal failure <input type="checkbox"/> Specific genitourinary disorder <p>Date of Onset: _____</p> <p>Doctor/Clinic: _____</p> <p>Rx: _____</p>		

NEUROMUSCULOSKELETAL & MOVEMENT RELATED FUNCTIONING

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/> Amputation-lower extremity <input type="checkbox"/> Amputation-upper extremity <input type="checkbox"/> Amyotrophic lateral sclerosis (ALS) <input type="checkbox"/> Arthritis <input type="checkbox"/> Back injury <input type="checkbox"/> Brain injury-hemiplegia <input type="checkbox"/> Burn injury <input type="checkbox"/> Cancer <input type="checkbox"/> Carpal tunnel syndrome <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Charcot-marie-tooth syndrome <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Diabetic neuropathy <input type="checkbox"/> Friedrich's ataxia <input type="checkbox"/> Guillain-barre syndrome <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Orthopedic impairment (Spec Ed) <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Paraplegia <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Stroke <input type="checkbox"/> Tendinitis <input type="checkbox"/> Tourette's syndrome <input type="checkbox"/> Specific neuromusculoskeletal disorders		
<p>Date of Onset: _____</p> <p>Doctor/Clinic: _____</p> <p>Rx: _____</p>		

FUNCTIONING OF THE SKIN & RELATED STRUCTURES

<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Tertiary
<input type="checkbox"/> Acne <input type="checkbox"/> Burn injury <input type="checkbox"/> Contact dermatitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Specific skin & related structure disorders		
<p>Date of Onset: _____</p> <p>Doctor/Clinic: _____</p> <p>Rx: _____</p>		

ASSISTIVE TECHNOLOGY

Check the box next to the following areas in which the consumer uses orthotic/prosthetic/assistive devices, technical aids, or environmental modifications/adaptions:

<input type="checkbox"/> Communication
<input type="checkbox"/> Environmental Control
<input type="checkbox"/> Handling Things
<input type="checkbox"/> Home Modifications
<input type="checkbox"/> Housekeeping
<input type="checkbox"/> Mobility
<input type="checkbox"/> Personal Care
<input type="checkbox"/> Recreation
<input type="checkbox"/> Training
<input type="checkbox"/> Vehicle Modifications
<input type="checkbox"/> Work Place Modifications