

MEDICAL EXAMINATION AND CAPACITY FORM

Client: _____ **Date:** _____

Please read the following information and answer the questions below. We will use your responses to determine the capacity of this individual to participate in work and self-sufficiency activities.

1. Date of last examination:

2. Diagnosis/Condition(s):

3. In your opinion, is the patient's condition severe enough to prevent them from working full-time? Yes No

4. In your opinion, can the patient work part-time? Yes No

If "yes," Please circle how many hours per day? 1 2 3 4 5 6 7 8

5. How long will the medical condition affect the patient's ability to work? (Please circle)

Less than one month 1 2 3 4 5 6

6. Does the patient's medication(s) cause side effects that may impact their ability to work or train? Yes No

If "yes" please specify: _____

What is the patient's treatment plan? (Please include type of activity & recommended hours of treatment per week)

Mental Health / Cognitive Abilities

Does this person have any mental health / cognitive difficulties that will cause the following to occur?

- | | | |
|---|---|---|
| <input type="checkbox"/> Low tolerance for frustration | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Socially inappropriate response |
| <input type="checkbox"/> Difficulty communicating needs | <input type="checkbox"/> Difficulty with decision-making | <input type="checkbox"/> Difficulty in unfamiliar environment |
| <input type="checkbox"/> Difficulty following instructions | <input type="checkbox"/> Difficulty controlling anger | <input type="checkbox"/> Difficulty with impulse control |
| <input type="checkbox"/> Inability to work with children | <input type="checkbox"/> Difficulty working around people | <input type="checkbox"/> Difficulty with reality perception |
| <input type="checkbox"/> Difficulty engaging in complex tasks that require judgment | | <input type="checkbox"/> Difficulty following through |

Other Condition(s)

Are there any other restrictions? _____

Name & Title of Licensed Health Professional (please print):		Address:
Signature:	Date:	Contact Number: