Preliminary Health Assessment Form of Persons with Disabilities

Date: .....

Name: ..... Gender: Female/ Male /Other

Date of Birth: .....Age: ..... Guardian's name: .....

Address: District: .....Municipality : ..... Ward No.: .....

Tole: ..... Contact No.: .....

General Health Check-up (General Assessment by General Physician/Medical Officer)

1. Chief Complain:

2. History of Illness:
   (Past)

   (Present)

3. Clinical Observation:

4. Provisional Diagnosis):

5. Recommended Intervention:

Assessed by:

Signature:

Eye Examination (Eye Assessment by Ophthalmologist/Optometrist).

1. Chief Complain:

2. History of Illness):
   (Past)

   (Present)

3. Clinical Observation:

4. Provisional Diagnosis:

5. Recommended Intervention:

Assessed by:

Signature:

Nose, Ear and Throat Examination (Ear, Nose & Throat Assessment by ENT Specialist/Audio and Speech Therapist/Technician).

1. Chief Complain:

2. History of Illness:
   (Past)

   (Present)

3. Clinical Observation:

4. Provisional Diagnosis:

5. Recommended Intervention:

Assessed by:

Signature:

Physiotherapy-Related Examination (Physiotherapy Assessment by Physiotherapist).

1. Chief Complain:

2. History of Illness:
   (Past)

   (Present)

3. Clinical Observation:

4. Provisional Diagnosis:

5. Recommended Intervention:

Assessed by:

Signature:

Psychiatrist/Psychologist:

1. Chief Complain:

2. History of Illness:
   (Past)

   (Present)

3. Clinical Observation:

4. Provisional Diagnosis:

5. Recommended Intervention:

Assessed by:

Signature: