Rehabilitation Services Driver Screening Intake

Welcome! Please fill this out to the best of your ability and return it to the front desk. Thank you!

Date: _____ Start of symptoms: _____

Reason for visit (pain, balance, etc.): _____

Height: _____ Weight: _____ Occupation: _____

Gender: _____ Pronouns (circle): She/Her He/Him They/Them Other

What do you do in your free time/what are your hobbies? _____

_____

Is there anything else you would like for us to be aware of? _____

_____

We want to know **your goals** to help us guide your care. Please list three important activities below that you are currently having difficulty with or cannot do.	**0 = Unable** to perform the activity									**10 = Able** to perform the activity at the same level as before the injury or problem
What activities do you find difficult because of your injury or problem? Please list them below and mark your current rating.	**CURRENT RATING**									
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1.											
2.											
3.											

Please check any symptoms that you are currently experiencing:

- ☐ Fever/Chills/Sweats
- ☐ Poor balance (falls)
- ☐ Unexplained weight loss
- ☐ Numbness or Tingling
- ☐ Changes in appetite
- ☐ Difficulty swallowing
- ☐ Depression
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Increased pain at night
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Difficulty concentrating/thinking
- ☐ Changes in bladder or bowel function

Please check any medical or surgical history we should be aware of:

- ☐ Arthritis
- ☐ Heart Condition
- ☐ Spinal Cord Injury
- ☐ Blood Clots
- ☐ Hernia
- ☐ Stroke/TIA
- ☐ Blood Disease
- ☐ High Blood Pressure
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Vision Problems
- ☐ Diabetes
- ☐ Kidney Disease/Dialysis
- ☐ Memory Problems
- ☐ Drug-Resistant Infection
- ☐ Liver disease/Hepatitis
- ☐ Other: _____
- ☐ Epilepsy/Seizures
- ☐ Lymphedema
- Are you pregnant/nursing? ☐ Yes ☐ No
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- Do you smoke? ☐ Yes ☐ No

Are you allergic to latex and/or adhesives? ☐ Yes ☐ No

Have you received any other therapy or alternative care treatments this calendar year?

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Chiropractic Treatment ☐ Acupuncture ☐ Massage Therapy

How many visits did you have?: _____ Clinic Name: _____

Please list a family member/friend who has observed you driving recently.

Name: _____

Phone Number: _____

May we contact this person for information regarding your driving? ☐ Yes ☐ No

Please answer the following questions <u>without assistance</u>.

1. Do you still drive? ☐ Yes ☐ No
   a. If yes, where and when? _____
   _____
   _____
   b. If no, where would you like to drive, and when would you do it? _____
   _____
   _____
   _____
2. How long have you been a driver? _____
3. Have you had any traffic incidents in the last five years? ☐ Yes ☐ No
   a. If yes, please explain: _____
   _____
   _____
4. What type of vehicle do you/did you drive? _____
5. How many doctors do you see, and for what conditions? _____
   _____
   _____
6. Are you taking any medications with side effects such as drowsiness or dizziness? ☐ Yes ☐ No
7. Have you had any falls or near-falls in the past six months? ☐ Yes ☐ No
8. Why do you think your doctor wanted your driving skills tested? _____
   _____
9. Do you have any fears about driving?_____
   _____

10. With the windows rolled up, can you hear a siren or horn?	Yes ☐	No ☐
11. Do you hear the sound of your turn signals?	Yes ☐	No ☐
12. Are objects bright and clear?	Yes ☐	No ☐
13. Does driving at night bother you?	Yes ☐	No ☐
14. Can you go out into the bright sunlight and see clearly right away?	Yes ☐	No ☐
15. Can you turn your head an equal distance from one side to the other?	Yes ☐	No ☐
16. Can you turn your head and neck far enough to see over your shoulder?	Yes ☐	No ☐
17. Can you drive as far as you want without your fingers or hands becoming tired, tingly, or numb?	Yes ☐	No ☐
18. Can you lift your arm high enough to adjust your rearview mirror?	Yes ☐	No ☐
19. Do you have trouble deciding when to enter a lane of moving traffic?	Yes ☐	No ☐
20. Do intersections confuse you?	Yes ☐	No ☐
21. Does driving make you angry?	Yes ☐	No ☐
22. Have your family members or friends expressed concern regarding your driving?	Yes ☐	No ☐

Do you have any additional information or comments that you would like to share about your driving? _____

_____

_____

_____

Drivers Quiz

(From the AARP Driver Safety Program)

Directions: Please read each question and mark the best answer.

1. Drivers aged 50 and over, compared with drivers aged 30-49, are involved in:
   - ☐ More crashes per mile
   - ☐ About the same number of crashes per mile
   - ☐ Fewer crashes per mile
   - ☐ It varies each year

2. Frequent use of mirrors on a car is especially important for those drivers who:
   - ☐ Drive a lot on highways
   - ☐ Have hearing problems
   - ☐ Drive a lot at night
   - ☐ Are driving unfamiliar cars

3. If you are planning to make a left turn across an intersection and you are waiting in the middle of the intersection for a break in oncoming traffic, your front tires should be turned:
   - ☐ To the left
   - ☐ It depends upon the sharpness of the turn
   - ☐ Straight ahead
   - ☐ To the right

4. You want to change lanes. You can see if another vehicle is in your blind spot:
   - ☐ Only if you check your rearview mirror
   - ☐ Only if you check your side-view mirror
   - ☐ Only if you turn and glance over your shoulder
   - ☐ Only if you check both mirrors

5. When entering a controlled access highway, turnpike, or freeway, you should:
   - ☐ Accelerate to the traffic speed and enter the highway by merging with traffic at the safest point
   - ☐ Stop at the end of the entrance ramp and look for an opening in the traffic
   - ☐ Proceed slowly and enter the highway when it is safe, trying not to stop
   - ☐ Accelerate to the traffic speed and entire the highway quickly because you have the right of way

6. The best response to a “Road Work Ahead” sign is to:
   - ☐ Continue driving at the posted speed limit and look for the road work
   - ☐ Look for the road work
   - ☐ Slow down and look for the road work
   - ☐ Brake and be prepared to stop

7. If the minimum speed limit on the freeway or highway is too fast to drive comfortably, a driver should:
   - ☐ Use the freeway only during non-rush hours and only in daylight
   - ☐ Stay to the right and drive very cautiously by keeping an eye on the rearview mirror
   - ☐ Keep off the freeway and select an alternate route
   - ☐ Stay in the right lane and use emergency flashers

8. If you take medication before driving, the most important thing for you to do is:
   - ☐ Have another person ride with you
   - ☐ Be sure to eat a light meal
   - ☐ Plan on making several rest stops along the way
   - ☐ Find out the effects of the medication and adjust your driving accordingly

9. The measure to be used by the driver aged 50 and over who is following a vehicle is:
   - ☐ 1 car length for every ten miles per hour you are traveling
   - ☐ 2-second following distance
   - ☐ 3-second following distance
   - ☐ 10 feet for every ten miles per hour you are traveling

10. When backing up, it is usually best to:
    - ☐ Open the left door and look back
    - ☐ Steer with one hand while looking into the rearview mirror
    - ☐ Steer with one hand while looking out the rear window
    - ☐ Steer with both hands while looking into the rearview mirror

11. Depth perception, which is important in knowing when to pass safely:
    - ☐ Increases with age
    - ☐ Remains the same with age
    - ☐ Decreases with age
    - ☐ Increases significantly with age

12. An icy road is more slippery at what temperature?
    - ☐ 32 degrees
    - ☐ 25 degrees
    - ☐ 10 degrees
    - ☐ 0 degrees

13. What is the number one traffic violation committed by drivers aged 50 and over?
    - ☐ Speeding
    - ☐ Following too closely
    - ☐ Failure to observe the right of way
    - ☐ Running a stop sign

14. What is the number two traffic violation committed by drivers aged 50 and over?
    - ☐ Speeding
    - ☐ Improper left turn
    - ☐ Tailgating
    - ☐ Running a stop sign

Caregiver/Family Questionnaire

Name of person filling out the form: _____

Please mark **yes** or **no** to the following behaviors you have observed or know about regarding the person who is being referred for a driver evaluation.

1. Incorrect signaling.	Yes ☐	No ☐
2. Pulls out into traffic when other cars are approaching.	Yes ☐	No ☐
3. Has difficulty keeping the car in the lane, crossing over the lane lines, or driving using two lanes so that other cars cannot use a driving lane safely.	Yes ☐	No ☐
4. Drives too slow or fast.	Yes ☐	No ☐
5. Has difficulty making decisions to proceed after stopping at a stop sign or light.	Yes ☐	No ☐
6. Has driven through a red light or a stop sign.	Yes ☐	No ☐
7. Has been stopped by a police officer.	Yes ☐	No ☐
8. Has received a ticket or a warning from a police officer.	Yes ☐	No ☐
9. Has been involved in an accident while driving.	Yes ☐	No ☐
10. Has stopped in traffic for no apparent reason.	Yes ☐	No ☐
11. Has gotten lost while driving.	Yes ☐	No ☐
12. Seems nervous while or after driving.	Yes ☐	No ☐

13. Please let us know of any other concerns you have regarding the driving ability of the person referred.

_____

_____

_____

_____