

DriveAbility

Exeter Healthcare, Inc.
Outpatient Rehabilitation Services
4 Alumni Drive
Exeter, NH 03833
(603) 580-7927

DRIVER EVALUATION HISTORY

1. CLIENT INFORMATION:

Name: _____ Date of Birth: _____
Address: _____
Telephone: _____

2. PARENT/GUARDIAN INFORMATION(IF APPLICABLE):

Name: _____ Telephone: _____
Address: _____

3. REFERRING AGENCY(IF APPLICABLE):

Name: _____ Telephone: _____
Address: _____
Contact Person: _____

4. PHYSICIAN/HOSPITAL INFORMATION:

Primary Physician: _____ Phone: _____

Date of last appointment: _____

Ophthalmologist/Optomtrist: _____ Phone: _____

_____ Date of last appointment: _____

Other Physicians:

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Hospital: _____ Date Discharged: _____

Hospital: _____ Date Discharged: _____

Rehab Center: _____ Date Discharged: _____

5. MEDICAL HISTORY:

Primary Diagnosis/Disability: _____

Date of Onset: _____ Primary Problems: _____

Height: _____ Weight: _____

Past Medical History (Please write yes/no to following diagnoses)

Where: _____ When: _____

If yes, do you have a completion certificate? _____

If no, please describe why your completion of the class was not successful

Do you have a current driver's license? _____ State: _____

License #: _____ Expiration Date: _____

If yes, are there any restrictions? (Please describe) _____

If no, have you ever held a driver's license? _____ State: _____

Was your license suspended or revoked? (Please describe) _____

Please list and describe any accidents or traffic violations you have experienced:

Have you ever been evaluated for driving before? _____

If yes, where? _____ When? _____

Do you currently own a vehicle? _____ Make: _____ Model: _____

Automatic or Standard: _____ 4 door or 2 door: _____

Options/Accessories: _____

If no, do you have a vehicle to practice in? _____ Make: _____

Model: _____ Automatic or Standard: _____

4 door or 2 door: _____ Options/Accessories: _____

Do you intend to purchase a vehicle? _____ When? _____

Make: _____ Model: _____ Automatic or Standard: _____

4 door or 2 door: _____ Options/Accessories: _____

7. MOBILITY STATUS:

Do you use any device for mobility (Wheelchair, cane, etc)? _____

Can you transfer in/out of a car? _____

Do you need any assistance with walking, transfers, stairs etc. (please describe)?

Do you require any other assistance at home or in the community (please describe)?

8. FUNDING:

How will your evaluation be paid for?

_____ Private Pay *Have rates been explained to you?* _____

_____ Special Education

_____ Vocational Rehabilitation *Counselor's Name:* _____

_____ Worker's Compensation *Counselor's Name:* _____

_____ Veteran's Benefits *Counselor's Name:* _____

_____ Other *Please Specify* _____

I have completed the driver evaluation history form fully and to the best of my abilities. I have provided DriveAbility at Exeter Healthcare with complete and accurate information. All the information provided is factual.

Client Signature
(In the case of a minor, signature
of client and parent/guardian)

Date