

SAMPLE HEALTH NEEDS CHECKLIST

NAME: _____ (Show date most recent exam was completed - Pencil in due date)

AREA	FREQUENCY	DUE	COMP	DUE	COMP	DUE	COMP	DUE	COMP	DUE	COMP	DUE	COMP
PRIMARY PHYSICIAN													
HEALTH SCREEN (i.e. PAP, TB test, etc.)													
IMMUNIZATIONS													
NEUROLOGIST													
PSYCHIATRIST													
DENTAL													
VISION													
HEARING													
ORTHOPEDIC													
PHYSICAL THERAPY													
OCCUPATIONAL THERAPY													
DIETICIAN													

(Show date of most recent lab draw and when results were received – pencil in due date)

LAB TEST	FREQUENCY		DUE	COMP	DUE	COMP	DUE	COMP	DUE	COMP	DUE	COMP
		DRAWN										
		Rec'd										
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