



<b>Organization Name:</b>	<b>Program Name:</b>	<b>Date:</b>
<b>Individual's Name</b> (First MI Last):	<b>Record #:</b>	<b>DOB:</b>

**Part A**  
**Brief Medical Screening**

Doctor's Name:	Address:	Phone Number:	Date of Last Exam:
Dentist's Name:	Address:	Phone Number:	Date of Last Exam:

**Has a Doctor EVER told you that you had any of the following conditions?**

Condition	Check One		Currently Under a Doctor's Care	Comment
	Now	Past		
Alzheimer's Disease or Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Blood Sugar-High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Blood Pressure (High)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Deafness or other hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Hyperlipidemia (High blood fat/Cholesterol and/or Triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Mobility Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Other Cardiac Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sight Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Weight (Obesity, Unexplained Gain or Loss)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Other physical related health conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	



<b>Organization Name:</b>	<b>Program Name:</b>	<b>Date:</b>
<b>Individual's Name (First MI Last):</b>	<b>Record #:</b>	<b>DOB:</b>

<b>CURRENT Medication Information</b> <input type="checkbox"/> None (Include all current medication-Psychiatric/Non-Psychiatric, Prescription/Over-the-counter drugs/Herbal)					
Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				<input type="checkbox"/> No <input type="checkbox"/> Yes	
				<input type="checkbox"/> No <input type="checkbox"/> Yes	
				<input type="checkbox"/> No <input type="checkbox"/> Yes	
				<input type="checkbox"/> No <input type="checkbox"/> Yes	
				<input type="checkbox"/> No <input type="checkbox"/> Yes	

**Additional:**

<b>Medication HISTORY Information</b> <input type="checkbox"/> None (As best as possible, list all additional medications taken for psychiatric or substance abuse issues in the past)					
Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				<input type="checkbox"/> No <input type="checkbox"/> Yes	
				<input type="checkbox"/> No <input type="checkbox"/> Yes	
				<input type="checkbox"/> No <input type="checkbox"/> Yes	

**Additional - Are there any medications you would like to avoid taking in the future?:**

**Allergies/Drug Sensitivities**  None

Food (specify):

Medicine (specify):

Latex /  Other (specify):

<b>Medical hospitalizations/significant operative and invasive procedures?</b>		
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete information below:		
Hospital	Date	Reason

**Comments:**



<b>Organization Name:</b>	<b>Program Name:</b>	<b>Date:</b>
---------------------------	----------------------	--------------

<b>Individual's Name (First MI Last):</b>	<b>Record #:</b>	<b>DOB:</b>
---	------------------	-------------

**Nutrition/Hydration Screening Check if you have experienced:**

1.  Any weight loss or gain of 10 pounds or more in the past three months
2.  Change in appetite
3.  Are you experiencing any other problems eating or drinking?

<b>The Joint Commission</b>	<b>Pain Screening</b>
Do you have any ongoing pain problems? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, Medical Staff completes pain section below.	

**For Women Only**

<b>Currently pregnant?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, expected delivery date:  <b>Are you currently breastfeeding?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>Menstruation</b> <b>Last menstrual Period Date:</b>  <b>Menstrual Pain:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>Menstrual Irregularities:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Other:	<b>Receiving pre-natal healthcare?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, indicate provider:  <b>Any significant pregnancy history?</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, explain:  <b>Pre-menstrual symptoms:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <b>Polycystic Ovary Syndrome?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  If yes, Indicate provider:
---	--

**For Children Only**

**Immunizations:** Has the child or adolescent been immunized for the following diseases? Please check all that apply.

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> German Measles (rubella)	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Polio	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Other:		

All immunizations up to date?  Yes  No – Comments:  
 Prenatal exposure to Alcohol or other Drugs?  Yes  No – Comments:  
**Any other significant information that may affect care or place the child or adolescent at risk (for example, accidents or injuries):**

<b>Completed By - Print Name:</b>	<b>Signature:</b>	<b>Date:</b>
-----------------------------------	-------------------	--------------





<b>Organization Name:</b>		<b>Program Name:</b>	<b>Date:</b>
<b>Individual's Name (First MI Last):</b>		<b>Record #:</b>	<b>DOB:</b>
<b>The Joint Commission</b>	<b>Was Last physical completed more than one year ago?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, document referral below:		
<b>Referrals and Recommendations</b>			
<b>OASAS</b>	<b>Based on Face to Face Medical Assessment:</b> <input type="checkbox"/> Individual requires physical exam- see referral below, OR		
	<input type="checkbox"/> Individual does not require physical exam		
<input type="checkbox"/> Nutrition/Hydration Referral: <input type="checkbox"/> Pain Referral: <input type="checkbox"/> Specialty Care:		<input type="checkbox"/> Primary Care Physician (General Referral): <input type="checkbox"/> Primary Care Physician for Physical Exam and Date, if known:	
<input type="checkbox"/> Other:			
<b>Comments, if indicated:</b>			
<b>Completed By - Print Staff Name/Credentials:</b>		<b>Staff Signature:</b>	<b>Date:</b>