HEALTH SCREENING Date of Last Physical Examination: _____ Date of Last Visit to Physician: _____	CLIENT'S NAME (Last, First, M.I.)
	CASE NUMBER:
	PROGRAM:

ALLERGIES (including adverse or allergic reactions): _____

_____

_____

1. MEDICAL PROVIDERS: Include name and address of regular healthcare providers (primary care, pain management, psychiatrist or other specialists)

Primary Care Provider	Address	Telephone Number	STAFF ONLY
			☐ Yes ☐ No ☐ Refused
Other Medical Providers (psychiatrist, pain management, other specialty physician)			
			☐ Yes ☐ No ☐ Refused
			☐ Yes ☐ No ☐ Refused

Pharmacy Name: _____ Phone #: _____

2. NUTRITIONAL SCREENING: *Please Make One Selection in Each Section*

Appetite: Good (0) ☐ Occasionally Poor (1) ☐ Persistently Poor (2) ☐

Recent changes in appetite: Yes (1) ☐ None (0) ☐

Food Allergies: Yes (1) ☐ None (0) ☐

Diet: Regular/Compliant with Restriction (0) ☐ On restricted diet, but not following (1) ☐

Weight: No significant change (0) ☐ Significant (10lbs or more) weight gain or loss in past three months (1) ☐

Swallowing or Chewing Problems: Persistent Problems (2) ☐ Infrequent or None (0) ☐

PLEASE TOTAL NUMBERS BELOW!

Total Points: _____

If score is > 5 points, client needs to discuss with PCP and **complete Section 7**.

CLIENT'S NAME:		CASE #:
3. GENERAL HEALTH PERCEPTIONS	NO	YES (explain)
Have the following changed in the last six (6) months?	NO	Yes, In what way has it changed?
Sleeping habits		
Energy level		
Amount of water you drink daily		
Urination frequency		
Bowel movement frequency		
Do you . . .	NO	Yes, How often?
Exercise		
Smoke		
Drink alcoholic beverages		
Drink coffee or tea		
Have you ever had . . .	NO	If you answer "Yes," explain in the space below.
Blurred vision		
Ringing in your ears; loss of hearing		
Head injuries		
Weakness, lightheadedness, dizziness		
Rapid heartbeat		
Pains, discomfort or tightening in chest		
Pain or discomfort in arm, joint or leg		
Discomfort or shortness of breath		
Swollen legs, ankles or feet		
Frequent nausea or vomiting		
Frequent diarrhea or constipation		
Painful or bloody bowel movements		
Painful urination or blood/dark urine		
Loss of urine when laugh, sneeze, cough		
Tendency to bleed or bruise easily		
Urinate only small amounts at a time		
Other (specify)		
If female . . .		
Pregnant		
Planning to become pregnant		
Nursing		
Menopause		
Vaginal itching, burning, discharge, tender breasts, discharge from nipples		
CLIENT'S NAME:		CASE #:

3. GENERAL HEALTH PERCEPTIONS (continued)	NO	YES (explain)
If female, Date of last period:		
Date of last PAP smear:		

4. ILLNESSES AND SYMPTOMS (Indicate if you or a blood relative have ever had any of the following conditions):

	No, I have not	Yes	If you answer "Yes," give date and type of treatment in space below.	Family History Specify Relative
Diabetes or sugar in your urine				
Cancer or tumor				
Heart trouble				
Epilepsy, seizures, convulsions				
Auto-immune disease				
Stroke				
Tuberculosis				
Sexually transmitted disease				
Thyroid problems or goiter				
Asthma, chronic lung problems				
Ulcers – stomach problems				
Hepatitis, liver problems				
Prostrate problems				
Chicken pox				
Kidney problems				
Tics/Tourettes				
Rheumatic fever				
Glaucoma				
High cholesterol				
High blood pressure				
Palliative Care				
Other (specify)				

CLIENT'S NAME: CASE #:

5. MEDICATION: (List all medications that you are currently taking. Include prescribed and non-prescribed drugs, amount and frequency; herbal remedies; vitamins, diet aids; nutritional supplements; health foods.)

Name	Dose	Frequency	Route

6. PAIN SCREENING

a. Do you experience pain? _____ Yes _____ No

b. Do you know the cause of the pain? _____ Yes _____ No

c. Are you receiving treatment for pain management? _____ Yes _____ No

If YES: Where: _____

By Whom: _____

Has the treatment been helpful? _____ Yes _____ No

Medication Prescribed: _____

d. How severe is the pain on a scale from 1 (no pain) to 5 (severe or constant pain) *Circle one:*

☐ 1 ☐ 2 ☐ *3 ☐ 4 ☐ 5 (3 is trigger for client to discuss pain with PCP)

Above information completed by**:** _____ Date: _____

Wellness Assessment (STAFF ONLY ↓)

B/P: _____ PULSE: _____ RESPIRATIONS: _____

HT.: _____ WT.: _____ BMI (Adults): _____

7. MEDICAL COORDINATION

Staff spoke with client about having discussion with PCP. Recommended to discuss: (*check all that apply*)

_____ Nutrition Screening/BMI _____ Pain Screening _____ No PCP, resources provided

_____ BP _____ Other

Above information completed by: _____ Date: _____

Reviewed by (Staff Signature & Credentials): _____ Date: _____

Reviewed by Medical Professional: _____ Date: _____
(where appropriate)