Client Name ____ Client ID ____________

Please answer these questions as they pertain to the person to receive service (the potential client.)	**HARBOR BEHAVIORAL HEALTHCARE** **Health Assessment - Part I** ***General Medical***

Clinician ______________________ Episode #__________ Client Height _______ and weight ______ lbs.

Person to notify in case of emergency:

Name ____ Relationship ________________________________

Address ____ Telephone __________________________________

Doctor or clinic you go to for basic medical care:

Name ______________________________________ Address ____

Date of last visit _______________________________ Date of last physical exam ______________________________

List any current or recent past health problems. Indicate if you are being treated or received treatment and by whom: ____

____

____

Explain any physical limitations or developmental disabilities: ____

____

List any hospitalizations you have had with dates and what they were for: ______________________________

____

____

____

Check <u>YES</u> if any of the following apply to you (the client) and <u>NO</u> if not…

YES	NO	
☐	☐	Do you smoke one or more packs of cigarettes a day?
☐	☐	Do you drink two or more alcoholic beverages a day?
☐	☐	Do you drink 5 or more cups of caffeinated beverages a day?
☐	☐	Are you sexually active?
☐	☐	Do you practice safe sex?
☐	☐	Any history of behaviors that may have led to exposure to the HIV virus?

QUESTIONS SPECIFICALLY FOR CHILDREN

☐	☐	Did the mother smoke during pregnancy?
☐	☐	Did the mother drink alcohol or use drugs during the pregnancy?
☐	☐	Has the child received the required immunizations?

QUESTIONS SPECIFICALLY FOR FEMALES *(Answer as it pertains to the female client.)*

☐	☐	Have you had a recent Pap smear? Date: ________________
☐	☐	Do you use birth control? Type: ________________________
☐	☐	Do you have any menstrual discomfort?
☐	☐	Are you going through menopause?
☐	☐	Are you pregnant? If yes, please list the doctor or clinic for prenatal care: Name: ____ Telephone _____________ Address ____ City __________________ Date of last exam ___________________________
☐	☐	Have you ever been pregnant? How many pregnancies? _______________________
☐	☐	Did you experience any complications during the pregnancy? If yes, please explain: ____

What happened to the pregnancies? Place a number in each space: ___ taken to full term
___ abortion ___ miscarriage ___ premature delivery ___ given up for adoptions

Client Name ____ Client ID ____________

Health History*: Check if you or any blood relative have or have had any of the following:*

	You	Relative		You	Relative		You	Relative
Anemia	☐	☐	Epilepsy / Seizures	☐	☐	Rheumatic fever	☐	☐
Arthritis or joint disease	☐	☐	Glaucoma / Vision problems	☐	☐	Sexually transmitted disease	☐	☐
Asthma or allergies	☐	☐	Gout	☐	☐	Sickle cell disease	☐	☐
Bladder trouble	☐	☐	Headaches	☐	☐	Stroke	☐	☐
Bleeding disorder	☐	☐	Heart disease/Chest pain	☐	☐	Suicide	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Swelling/Water retention	☐	☐
Deafness or hearing loss	☐	☐	High blood pressure	☐	☐	Thyroid disease	☐	☐
Diabetes, sugar	☐	☐	Hypoglycemia, low blood sugar	☐	☐	Tuberculosis	☐	☐
Drugs/Alcohol use/Abuse	☐	☐	Kidney disease	☐	☐	Ulcers	☐	☐
Emphysema/Problems breathing	☐	☐	Mental illness	☐	☐	Urination problems	☐	☐

Health Assessment – Part II
Nutrition Assessment

ADULTS – PLEASE COMPLETE…

Part A:

After I eat, I worry about gaining too much weight.	Yes	No
I feel I should be dieting today.	Yes	No
How many diets have you tried in the last year?	1 2 3 4 5+	
I feel dissatisfied with my body size.	Yes	No
I am afraid of becoming too fat.	Yes	No
Weight affects the way I feel about myself.	Yes	No

Part B:

Do you often skip meals or have a poor appetite?	Yes	No
Have you lost over 10 pounds in the last six months without trying to?	Yes	No
Please rate your typical appetite from “1” (poor) to “10” (good)		
Do you have tooth or mouth problems that make it hard to chew or do you have problems swallowing?	Yes	No
Have you been told by a professional to cut down on salt, sugar, or fat in your diet?	Yes	No
Do you have an illness or health problem that has made you change the types of amounts of food you eat?	Yes	No
Do you currently have problems with nausea, vomiting, diarrhea, or constipation?	Yes	No
Have you had surgery in the last month or an illness that has lasted for more than three weeks?	Yes	No

CHILDREN and ADOLESCENTS **Client Age:** ___________

(Parent, Guardian or Responsible Party, please answer for or assist the child with answering these questions)

1. Have you had unplanned weight loss or gain of more than ☐ 3 lbs in 1 week; ☐ 7 lbs in 1 month; ☐ 10 lbs in 3 months; ☐ 14 lbs in 6 months?
2. What is your usual weight? ___________ lbs.
3. Are there any foods you are allergic to? ☐ Yes ☐ No If yes, list the foods you are allergic to: _________________ ____
4. How would you describe your appetite? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ No appetite
5. Weight affects the way I feel about myself. ☐ Yes ☐ No
6. Have you had any of the following problems for at least one week? Check all that apply: ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Mouth sores
7. I have not felt like eating for at least 2 weeks. ☐ Yes ☐ No If yes, explain: ______________________________
8. I feel dissatisfied with my body size. ☐ Yes ☐ No
9. I have a hard time getting enough food to eat. ☐ Yes ☐ No If yes, explain: ______________________________
10. I have a history of eating or drinking non-food items such as dirt, clay or paint. ☐ Yes ☐ No

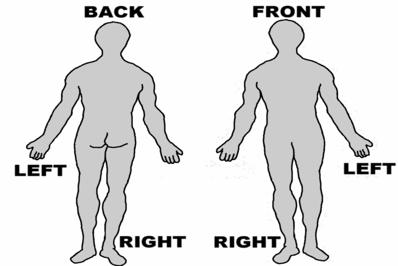
Parent/Guardian/Responsible Party – do you have concerns about the child’s eating habits? ☐ Yes ☐ No
If yes, please explain: ____
____

Client Name ____ Client ID ____________

Health Assessment – Part III
Pain Assessment

Do you have pain? ☐ **Yes** ☐ **No** *If yes, please answer the following pain questions:*

Please **WRITE ON / IDENTIFY** parts of the body affected by pain.



Tell us the character or type of pain by using the code below:

- ● DULL
- ≈ BURNING
- → SHOOTING
- ▷ SHARP
- ✕ THROBBING

√ How much does your pain hurt? (What is your pain intensity/severity?) *Please circle a number below:*

No hurt	Hurts a little *(Mild & annoying)*		Hurts more than a little *(Nagging, uncomfortable, troublesome)*		Hurts even more *(Miserable, distressing)*		Hurts a whole lot *(Intense, dreadful, horrible)*		Hurts Worse *(Worst pain possible, unbearable)*	
0	1	2	3	4	5	6	7	8	9	10

√ How long have you had this pain? ______________________________

√ How often do you experience pain (frequency/duration)? ______________________________

√ What causes you to have pain or what causes the pain to increase? ______________________________

____

√ What makes your pain better or worse? ______________________________

√ Do you get treatment for your pain: ☐ Yes ☐ No

√ How does your pain affect your functioning or quality of life? *(please circle number)*

Does not limit activities		Can do most activities with rest period		Unable to do some activities		Unable to do most activities		Unable to do any activities	
1	2	3	4	5	6	7	8	9	10

Current doctor treating your pain: Name: ______________________________

Address: ____

What pain treatments have you received?

☐ Acupuncture	☐ Physical Therapy or Massage
☐ Biofeedback (or other psychological care)	☐ Spinal Stimulator
☐ Braces or supports	☐ Surgery (explain) ______________________
☐ Chiropractic Care	______________________________
☐ Epidural Injections	☐ TENS: Transcutaneous (through skin) Electrical Neural Stimulation
☐ Nerve Blocks	☐ Other: ______________________________
☐ Pain Management Care (which facilities and where) ______________________________	

For Clinicians Use…

Acute versus Chronic Acute Pain→ immediate referral Chronic Pain→ referral if client requests Frequency	Severity Severity over 3-4/10 triggers more questioning. Rating 5+ - further assessment/referral indicated Affect on quality of life

______________________________________ ______________________

Client, Parent/Guardian or Responsible Person Signature Date

Reviewed by: ______________________________ ______________________

Medical Staff Signature Date

ms: 4/06, 6/06 *(Referral letter for further physical health care services sent:* ☐ *Yes* ☐ *Not indicated)*

Client Name ____ Client ID ____________

CURRENT MEDICATIONS

1. Do you have any known allergies to foods or medications? ☐ Yes ☐ No If Yes, please explain:
____

2. Please list all prescribed and over-the-counter medications that you take including vitamins, dietary supplements, herbals.

Date Reviewed	Name	Dosage	How often taken	Reason for taking medication	Do you take this regularly?	Physician who prescribed	Discon-tinued

ms: 4/06, 6/06