Department of Mental Health and Addiction Services
HEALTH SCREEN
Client name: **MPI #:**
Date:

VITAL SIGNS:

☐ **Client Declined**

BP: Pulse: Temperature: Respiration:
Height: Weight: lbs BMI:
☐ Underweight BMI < 18.5 ☐ Normal weight BMI 18.5 - 24.9 ☐ Overweight BMI 25 – 29.9 ☐ Obese: BMI = 30 or greater
Waist Circumference: inches (Normal: Women below 35 inches; Men below 40 inches)

ALLERGIES:

Describe any allergies, sensitivity and/or reactions (to medicines, foods, etc.)?

ALL CURRENT MEDICATIONS

Psychiatric Medication ☐ **None**		**Dose / Route / Frequency** - If injection, date last given -	**Purpose**	**Prescriber**
Other Medication ☐ **None**		**Dose / Route / Frequency** - If injection, date last given -	**Purpose**	**Prescriber**

ALL CURRENT MEDICATIONS (cont.)

OTC Medication including Vitamins/Herbal ☐ None		**Dose / Route / Frequency**	**Purpose**

HOW DO YOU VIEW YOUR OWN HEALTH (CLIENT'S OWN WORDS)

ACUTE & CHRONIC MEDICAL CONDITIONS (active or by history):

☐ Mental Illness ☐ High cholesterol ☐ High Blood Pressure ☐ Heart disease ☐ GERD

☐ Arthritis ☐ Headaches ☐ Head injuries ☐ Seizures/ convulsions ☐ STD

☐ Glaucoma/cataracts ☐ Sleep Apnea ☐ Thyroid Disease ☐ Kidney disease ☐ Diabetes

☐ Cancer ☐ Hepatitis ☐ Cirrhosis ☐ HIV infection ☐ Pancreatitis

☐ Prostate ☐ UTI ☐ Asthma/ Tuberculosis / COPD

☐ Nicotine Addiction ☐ Drug/Alcohol Addiction

☐ Other medical or dental problems (specify):

Are you sexually active? ☐ **Yes** ☐ **No** If Yes, do you practice safe sex? ☐ **Yes** ☐ **No**

Do you use contraceptives? ☐ **Yes** ☐ **No** If yes, what?

(if applicable) ☐ Pregnant or planning to become Date last Menses:

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Comments: (for the illnesses checked above include treatment history)

MEDICAL AND FAMILY HISTORY *(describe any illnesses or conditions that run in the family such as heart disease, diabetes, cancer, etc.)*

OTHER HEALTHCARE PROVIDERS

Do you currently have a primary care provider? ☐ **Yes** ☐ **No** Date of last Physical:

If yes, please include name, address & phone:

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Other medical specialists (please identify type: Dental, Vision, OBGYN, etc. and name address and phone)

PHYSICAL COMPLAINTS *(such as weight gain/loss, dizziness, palpitations, etc.)*

PAIN ASSESSMENT:

Are you currently or have you recently been in pain? ☐ Yes ☐ NoIf yes, describe?

Location
Quality of Pain
Duration
Circumstance

Severity 10 Point Scale, "0" being no pain and 10 being worst pain, rate pain

If yes, are you receiving treatment? ☐ Yes ☐ No

If yes, where?

If no, do you want a referral for treatment ☐ Yes ☐ No

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NUTRITIONAL SCREENING:

	YES	NO
1. Do you have an illness or condition that requires a change in the kind & amount of food you eat?		
2. Do you eat less than two meals per day?		
3. Do you seldom eat fruits, vegetables, or milk products?		
4. Do you have three or more drinks (beer, liquor, wine) almost every day?		
5. Do you have tooth or mouth problems that make it difficult for you to eat?		
6. Have you ever been told you had diabetes or high cholesterol?		
7. Do you eat alone most of the time?		
8. Do you take three or more different prescribed or over-the-counter drugs per day?		
9. Have you lost or gained ten pounds or more, without wanting to, in the past six months?		
10. Are you physically unable to shop, cook, and/or feed yourself?		
TOTAL		

SCORE	**ACTION**
0 – 2	None required
3 – 5	Encourage follow-up with Primary Care
6+	Clinician to make Referral to Primary Care & Review Plan of Care
Additional Comments:	

What tobacco/nicotine cessation related services/activities were received by the person in the past 90 days? *(select all that apply)*

☐ N/A
☐ Refused ☐ None
☐ Individual Intervention ☐ Group Intervention
☐ Educational Materials ☐ Rewards to Quit Program
☐ Nicotine Replacement Therapy (gum, lozenges, patch, etc.)

BARRIERS TO RECEIVING TREATMENT *(fears, transportation, disorientation, entitlements, neurocognitive, etc.)*

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RECOMMENDATIONS

☐ Refer client to seek treatment from primary health care provider if:

- Client has not had a physical exam within the past 12 months.
  Recommendation: _____
  AND/OR
- Client has an acute or chronic health problem that is not being treated by a primary health care provider
  Recommendation: _____

☐ Not indicated at this time

☐ Other recommendations: (specify) _____

I have reviewed my health status with my health care professional and I understand the recommendations made regarding medical care. I understand that failure to follow these recommendations may be harmful to my health.

Client's signature: _____ Date & Time: _____

☐ Client refused/unwilling/unable to sign

Reason for non-signature: _____

SCREENING COMPLETED BY: _____ _____
PRINT DATE

_____ _____
SIGNATURE TIME