DELAWARE COUNTY
MENTAL HEALTH / ALCOHOL AND DRUG ABUSE CLINICS

Medical Assessment / Health Screening Form

PLEASE COMPLETE AS MUCH AS POSSIBLE.
THE GRAY AREAS ARE FOR INTERNAL USE ONLY.

Name: ____**M / F** **ID#**: _______**Counselor Initials: _______**

Date of Birth:_________________________ **Height: _______________ Weight: ______________**

Primary Care Physician Name & Address: ____

Date of Last physical exam: ____/____/______

PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS			
MEDICATION	DOSAGE	WHEN TAKEN	PRESCRIBED BY
1.			
2.			
3.			
4.			
5.			
6.			

Medical/Psychiatric Diagnosis
1.
2.
3.
4.
5.
6.

Any changes in…	Yes	No	If yes, please explain
Appetite			
Weight			
Sleeping Habits			
Energy Level			
Do you…			
Use tobacco / vape			
Drink alcohol			
Drink coffee / tea / energy drinks			
Use nonprescribed drugs			
Use medical marijuana			

Have you ever had…	Yes	No	If yes, please explain
Head injuries			
Lung infection			
Migraines, blurred vision			
Light headedness, dizziness			
Medication allergies or bad reactions to medications			
Allergies			
Surgery			
Diabetes			
Cancer/tumor			
Heart problems/ rapid heart beat/ high blood pressure			
Epilepsy/seizures			
Asthma			
Thyroid problems or goiter			
Chronic pain issues			
Traveled out of the country or had contact with anyone who has traveled out of the country within the last 21 days?			
Females:			
Are you pregnant?			
Do you have regular periods			

COMMUNICABLE DISEASES			
	Tested within last year?	Results	Notes
Tuberculosis			
Hepatitis			
Ringworm			
Meningitis			
MMR			
Sexually Transmitted Diseases (ages 10 and over)			
	Tested within last year?	Results	Notes
HIV			
Gonorrhea			
Venereal Warts (HPV)			
Herpes			
Chlamydia			

Is the following testing clinically indicated?

HCV ☐ Yes ☐ No TB ☐ Yes ☐ No HIV ☐ Yes ☐ No

If yes, please document referral information: Provider: ______________________________

Date and Time of Appointment: ______________________________

If patient declines testing please have patient sign and date below.

______________________________ ______________
Signature Date

Waiting for Medical Records: ____________________ Physical scheduled: ____________________

☐ Release for records signed

☐ No primary care provider. Discussed need to obtain provider

It has been determined that as a result of this assessment, the patient:

☐ **is in need of physical**

☐ **is not in need of physical**

Patient is to obtain physical exam from: ______________________________

Other Recommendations: ___ No; ___ Yes ______________________________

____

____

______________________________ ______________
Signature (Medical Staff person /Title) **Date**