Health Care for the Homeless
INFORMATION RESOURCE CENTER
888/429-3300 • Fax 518/439-7612

#2. GENERAL MEDICAL – ASSESSMENT / RECORDS

Addiction TB screening / assessment form (BAL 20)
Adult physical examination (*WES 10*)
Adult physical examination (*STL 3*)
CIWA-A/narcotic withdrawal scale (*POR 10*)
Clinical assessment (*WES 1a*)
Clinical assessment for alcohol and drug client - Client Form B (*WES 1b*)
Clinical assessment supplemental data (*WES 1c*)
Clinical staffing notes (*TER 3*)
Diagnosis testing follow-up form (*BAL 32*)
Family planning history/physical exam (*WES 9*)
Fever - child (*HPH 8*)
Fungal infection of foot (*HPH 7*)
Gynecology exam (*HHH 1*)
Head Lice (*HPH 6*)
Health history and physical exam (*BAL 6*)
Health maintenance assessment form– 1 month through adolescent (*CAM 6 a – 6p*)
Immunization record (*CAM 18*)
Mammogram questionnaire (*BAL 45*)
Medical examination (*HOM 10*)
Non-productive cough (*HPH 5*)
Nursing assessment form (*BAL 15*)
Otitis (*HPH 3*)
Pediatric developmental milestones (*MON 14*)
Pediatric screen (*MER 7*)
Poison Oak (*HPH 4*)
Viral "flu" syndrome (*HPH 2*)
Women's health form (*CAM 5*)

BAL 20

HEALTH CARE FOR THE HOMELESS

ADDICTION TB SCREENING / ASSESSMENT FORM

Date:	Client Date of Birth:	SS#:	Sex:	Race:

Client Address:	Phone:
Contact Person (Next of Kin:)	**Phone:**

I. TB HISTORY

1. Do you currently have any of the above symptoms: (Mark all that apply)

Symptoms	Yes	No	
Night Sweats?			
Fatique?			
Persistent Cough?			**If yes, refer to HCH Medical Team Leader**
Blood in Sputum?			**If yes, refer to HCH Medical Team Leader**
Unexplained Weight Loss?			

2. Date of last TB test: _____

3. Previous history of TB disease? [ ] Yes [ ] No [ ] Unknown
   If yes, Where and When _____

4. Previous Positive TB skin test? [ ] Yes [ ] No [ ] Unknown
   If yes, Where and When _____

5. Did you take medication? [ ] Yes [ ] No [ ] Unknown
   If yes, Name and duration of treatment _____

6. History of Negative TB skin test? [ ] Yes [ ] No [ ] Unknown
   If yes, Where and When _____
   If greater than 12 months since last test, refer to HCH Medical Team

II. TB RISK ASSESSMENT

	Yes	No	Unk
1. HIV Infection?			
2. History of injection drug use?			
3. Are you aware of any close exposure in last 24 months to someone with active TB?			
4. Is Client enrolled in Methadone, Intermediate Care Facility or Therapeutic Community Program?			

If answer is "No" to Questions 1, 2, 3 and 4 - referral for skintest is not needed. Do Not Complete Rest of Form

III. REFERRAL INFORMATION FOR TB SKIN TEST

Date of Referral: _____

CLIENT LAST NAME:		FIRST:		HCH#:	

IV. CONSENT FORM

The Purified Protein Derivative (PPD) test is administered annually to clients to screen for exposure to Tuberculosis. **If you have ever had a positive reaction to a tuberculosis test, you should not receive the PPD Test.**

To the best of my knowledge, the above information is complete and accurate regarding my history of Tuberculosis screening. I have reviewed the above information and have had an opportunity to ask questions. Since a medical provider must interpret the PPD results, I understand I will return to the medical clinic within three days to obtain my results. I consent to receiving the PPD screening test.

_____ _____

Client Signature Date

V. FOLLOW-UP REPORT

☐ Client received skin test and had it read

Date Given: _____

Results: _____

☐ Client had skin test-did not return for reading

☐ Client never kept appointment for TB screening

VI. DECLINATION STATEMENT

I have been assessed as needing a TB skin test, but have chosen not to have one. I do realize that I am at risk of contracting this disease.

_____ _____

Signature Date

ADDITIONAL COMMENTS:

_____ _____

Counselor Date

WES 10

MULTNOMAH COUNTY
HEALTH DEPARTMENT

*Adult Physical Exam Form

* Use only for non-Family Planning physicals

HCT ____ U/A ____ PAP ____ GC ____ CT ____ VDRL ____ HIV ____ LMP _____ Pgt. Test _____

General Appearance _____

See Patient Parameter sheet for vital signs (POR-601)

N	AB	1. SKIN
		Appearance
		Texture
		Temperature
		Moisture
		Color
		Nails
		Hair
N	**AB**	**2. HEAD**
		Skull
		Scalp
N	**AB**	**3. EYES**
		Vision
		Visual fields
		E.O.M.
		Eyelids
		Eyeballs
		Occular tension
		Conjunctivae
		Cornea
		Sclera
		Lens
		Pupils
		Fundi
N	**AB**	**4. EARS**
		Hearing
		Pinna
		Canals, drums
		Rine, Weber
N	**AB**	**5. NOSE**
		Shape
		Mucosa
		Septum
		Turbinates
		Sinuses
N	**AB**	**6. MOUTH/THROAT**
		Lips
		Breath
		Teeth, gums
		Tongue
		Mucosa
		Tonsils
		Pharynx
		Larynx
		Salivary glands

COMMENTS

N	AB	7. NECK
		Motion
		Shape
		Trachea
		Thyroid
N	**AB**	**8. BREASTS**
		Breasts
N	**AB**	**9. NODES**
		Occipital
		Neck
		Supraclavicular
		Axillary
		Epitrochlear
		Inguinal
N	**AB**	**10. CHEST**
		Shape
		Thoracic wall
		Motion
N	**AB**	**11. LUNGS**
		Respirations
		Fremitus
		Resonance
		Diaphragm
		Breath sounds
		Voice sounds
		Extra sounds
N	**AB**	**12. VASCULAR**
		Pulse character
		Neck veins
		Peripheral veins
N	**AB**	**13. HEART**
		Inspection
		Palpation
		Percussion
		Rate. rhythm
		S1
		S2
		Systole
		Diastole
		Precordial sounds

Client Name _____

Birth Date _____

N	AB	14. ABDOMEN
		Abdominal Wall
		Inspection
		Palpation
		Liver
		Spleen
		Resonance
		Ausculation
		Anus
		Anal Sphincter
		Rectum
		Stool Guiac
		Prostate
N	**AB**	**15. GENITALIA**
		MALE
		Penis
		Scrotum
		Testes
		Epididymis
		Inguinal Canal
		FEMALE
		External Genitalia
		Vagina
		Cervix
		Uterus
		Adnexae
		Rectovaginal

COMMENTS

N	AB	16. MUSC. SKEL.
		Spine
		Back
		Muscles
		joints
		Upper Extrememities
		Lower Extrememities
N	**AB**	**17. NEURO**
		Cranial Nerves
		Motor
		Sensory
		Gait
		Coordination
		Path. Reflexes

18. PULSE	R	L
Occipital		
Brachial		
Radial		
Femoral		
Popliteal		
Postibial		
D.Pedis		
19. REFLEX	**R**	**L**
Biceps		
Brachioradialis		
Triceps		
Knee		
Ankle		
Abdominal		
Cremasteric		
Plantar		

SEE PROGRESS NOTES FOR ASSESSMENT & PLAN

Client Name _____ Birth Date _____

Examiner _____ Date _____

STL 3

HEALTH CARE FOR THE HOMELESS PROGRAM
ADULT PHYSICAL EXAMINATION

AP8

Today's Date: _____/_____/_____ Shelter/Program_____
M D Y

Name: _____ Birthday: _____

Sex:..Male..Female Race:..White..Black..Sp. Am...Other_____

Temp_____ Pulse_____ Resp_____ BP_____ Wt_____ Ht_____

HISTORY & PHYSICAL FINDINGS:

Diagnosis:

Treatment:

Medication:

Referral:

Health Care Provider_____ Date _____

POR 10

CIWA-A Scale

Temp _____ Pulse _____ Resp _____ BP _____ BAL _____	Score
Nausea and Vomiting 0 None 1 Mild nausea with no vomiting 4 Intermittent nausea with dry heaves 7 Nausea, dry heaves, vomiting	
Tremor (arms extended, fingers spread) 0 No tremor 1 Not visible - can be felt fingertip to fingertip 4 Moderate with arms extended 7 Severe even with arms not extended	
Sweating (observation) 0 No sweat visible 1 Barely perceptible, palms sweats 4 Beads of sweat visible 7 Drenching sweats	
Tactile Disturbances 0 None 1 Very mild itching, pins and needle or numbness 2 Mild itching or pins and needles, burning or numbness 3 Moderate itching, pins and needles, burning or numbness 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Fused	
Visual Disturbances - Ask, "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" 0 Not present 1 Very mild sensitivity 2 Mild sensitivity 3 Moderate sensitivity 4 Moderately severe hallucinations (Intermittently fused) 5 Severe hallucinations 6 Extremely severe hallucinations 7 Fused	
Auditory Disturbances - Ask, "Are you more aware or sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" 0 Not present 1 Very mild harshness or ability to frighten 2 Mild harshness or ability to frighten 3 Moderate harshness or ability to frighten 4 Moderately severe hallucinations (occasionally fused) 5 Severe hallucinations 6 Extremely severe hallucinations 7 Fused	
Orientation and clouding of Sensorium (What day is this? What is this place? 0 Oriented and can do serial additions 1 Cannot do serial additions or is uncertain about date 2 Disoriented for date by no more that 2 calendar days 3 Disoriented for date by more than 2 calendar days 4 Disoriented for place and/or person Reorient to time, place and person if necessary	
Anxiety (Observation, Do you feel nervous?) 0 No anxiety; at ease 1 Mildly anxious 4 Moderate anxious or guarded, (Anxiety Inferred) 7 Equivalent to panic states as seen in severe delirium acute schizophrenic reactions	
Agitation (Observation) 0 Normal activity 1 Somewhat more than normal activity 4 Moderately fidgety and restless 7 Pacing, or thrashing about constantly	
Headache, fullness in head. Ask, "Does your head feel different? Does it feel like a band around your head?" Do no rate for dizziness or light-headedness. Otherwise, rate severity. 0 Not present 1 Very mild 2 Mild 3 Moderate 4 Moderately severe 5 Severe 6 Very severe 7 Extremely servere	
Insomnia 0 Able to sleep uninterrupted 1 Complains of difficulty falling asleep 4 Awake one-half of time 7 Awake throughout night	

033R (Rev. 02/93) Date: Time: NURSE _____ TOTAL SCORE _____

Narcotic Withdrawal Scale

(Fultz & Senay, 1975)

Underline signs & symptoms, and circle grade.

Grade 1: lacrimation, rhinorrhea, diaphoresis, yawning, restlessness, insomnia

Grade 2: dilated pupils, piloerection, muscle twitching, myalgia, arthralgia, abdominal pain

Grade 3: tachycardia, hypertension, tachypnea, fever, anorexia, nausea, extreme restlessness

Grade 4: diarrhea, vomiting, dehydration, hyperglycemia, hypotension, curled-up position

Staff_____

Date_____

Time_____

Multnomah Clinical Assessment	Client's Name:	Evaluator's Name:
Dimension 1. Detox/Withdrawal + DSM IV Diagnosis	Circle "E" if symptom ever occurred but was not reported in the past year. Circle "1" if symptom occurred only once in the past year. Circle "2+" if symptom occurred two or more times in the past year.	

Indicator	Alcohol	Cannabis	Sed./Hypn.	Halluc.	Amphetamin	Cocaine	Opiods	PCP	Inhal.	Other
1. Tolerance a. Increased amount for same effect	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
b. Decreased effect for same amount	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
2. Withdrawal a. Withdrawal syndrome	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
b. Use to avoid withdrawal	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
3. Use of larger amounts or for longer period of time than intended	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
4. Desire or unsuccessful attempts to cut down or control use	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
5. A great deal of time is spent obtaining, using, or recovering	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
6. Social, work, or play activities are given up or reduced by use	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
7. Continued use despite recurrent physical or psychological problem	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
8. Most recent usual route of administration										
9. Frequency of use										
10 a. Longest period clean/sober (last 30 days)										
b. Longest period clean/sober (last 10 years).										
11. Date of last use										
A. Failure to fill roles at work, school, or home because of use	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
B. Recurrent use in hazardous situations	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
C. Recurrent legal problems due to use	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
D. Continued use despite social or interpersonal problems	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
Substance Dependence Requires pattern of impairment or distress with three or more of the indicators 1-7 occurring at any time in the last 12 months. (Check as appropriate)	303.9	304.30	304.10	304.50	304.40	304.20	304.00	304.90	304.60	304.90
Substance Abuse Requires pattern of impairment or distress with one or more of the indicators A-D occurring within the last 12 months. (Check as appropriate)	305.00	305.20	305.40	305.30	305.70	305.60	305.50	305.90	305.90	305.90

WES 1a-1

WES 1a-2

Multnomah Clinical Assessment	Client's Name:

	Age 1st Use	Age Reg. Use	Age Heaviest Use	Past Frequency	Past Amount	Last Use	Current Frequency	Current Amount	# of Days Used In Last 30	*Route of Admin.
Alcohol										
Cannabis (hashish, pot, grass)										
Sedative/Hypnotic (sleeping pills, Quaaludes)										
Barbiturates										
Tranquillizers										
Hallucinogens (LSD, mescaline, peyote psychedelics, psilocybin, DMT)										
Amphetamine										
Methamphetamine										
Cocaine (coke)										
Crack										
Heroin (speedballs)										

Multnomah Clinical Assessment	Client's Name:

	Age 1st Use	Age Reg. Use	Age Heaviest Use	Past Frequency	Past Amount	Last Use	Current Frequency	Current Amount	# of Days Used In Last 30	*Route of Admin.
Other opiates (codeine, Demerol, morphine, methadone, Darvon, opium, Dilaudid)										
Non-prescription Methadone										
PCP (Angel dust)										
Inhalants (Huffing, paint, gasoline, aerosols)										
Over-the-Counter										
Other Drugs										
Pathological Gambling										

1. How old were you the first time you used or tried any drug? _____

2. What is the client's:
   Primary Substance _____
   Secondary Substance _____
   Tertiary Substance _____

3. What is client's longest period clean/sober (last 30 days)? _____
   What is client's longest period clean/sober (last 10 years)? _____

4. Do you smoke cigarettes or use any other nicotine-based product (cigars, pipes, chewing tobacco)? ☐ Yes ☐ No

*Select the most usual route of administration from the following:

Oral
Smoking
Inhalation
Intramuscular Injection
Intravenous Injection
Other
Not Applicable (i.e., gambling)

WES 1a-3

Multnomah Clinical Assessment	Client's Name:

	Alcohol	Canna-bis	Sed/ Hypn.	Halluc.	Amphet.	Co-caine	Opiods	PCP	Inhal.	Other
1. Has your tolerance to Alcohol/Drugs increased so that you have to drink/ use more to get the same effect? (D1)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
2. Has your tolerance to Alcohol/Drugs decreased so that you have to drink/ use less to get the same effect? (D1)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
3. Have you ever used Alcohol/Drugs to avoid hangovers, shakes or other withdrawal symptoms? (D2)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
4. Have you ever had any withdrawal symptoms when you cut down or stopped using Alcohol/Drugs? (Note: headache, nausea, vomiting, anxiety, depressed mood, irritability, tremors, sweating, rapid heartbeat, diarrhea, disturbed sleep, inc. dreaming.) (D2)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
5. Has there been a time when you used Alcohol/Drugs in larger amounts or for longer periods then you intended? (D3)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
6. Have you ever wanted to stop using Alcohol/Drugs but couldn't? (D4)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
7. Have you ever felt as though your life revolved around your use of Alcohol/ Drugs? (D5)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
8. Has there been a time in your life when you used Alcohol/Drugs daily? (D5)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
9. Have you ever spent most of the day using Alcohol/Drugs or most of the day getting over the effects of use? (D5)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
10. Have you ever been unable to do something you planned because of Alcohol/Drug Use? (D6)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+

WES 8.4

Multnomah Clinical Assessment	Client's Name:

	Alcohol	Canna-bis	Sed/ Hypn.	Halluc.	Amphet.	Co-caine	Opiods	PCP	Inhal.	Other
11. Has your Alcohol/Drug use ever caused you to lose a job or be expelled from school? (D6)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
12. Have you ever continued to drink when you knew you had a physical or emotional problem that might become worse with continued use? (D7)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
13. Have you ever had problems with memory or concentration because of Alcohol/Drug use? (D7)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
14. Have you ever missed school or work (or taken sick leave) because of Alcohol/Drugs? (A1)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
15. Have you ever neglected your responsibilities to yourself or your family because of Alcohol/Drugs? (A1)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
16. Have you ever been in a hospital/emergency room because of Alcohol/Drugs? (A2)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
17. Have you ever had an injury while using Alcohol/Drugs that required medical attention? (A2)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
18. Have you ever been stopped or arrested for D.U.I.I.? (A2/A3)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
19. Have you ever been more likely to engage in risky sexual activity when you were using Alcohol/Drugs? (A2)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
20. Have you ever been arrested for any illegal involvement with drugs? (possession, sales, mfg., etc.) (A3)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
21. Have you ever gotten into fights after using Alcohol/Drugs? (A4)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+
22. Has anyone ever objected to your use of Alcohol/Drugs? (A4)	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+	E 1 2+

Wes I A-5

WES 1a-6

Multnomah Clinical Assessment	Client's Name:

Dimension 1. Detox/Withdrawal + DSM IV Diagnosis Continued

[Is there current risk of withdrawal?] **(interviewer only)** ☐ Yes ☐ No

Notes:

_____

_____

_____

Dimension 2. Physical Health Conditions And Complications

1a. [Has the Infectious Disease Risk Assessment been completed?] **(interviewer only)** ☐ Yes ☐ No

1b. [Was referral for medical screening/testing made?] **(interviewer only)** ☐ Yes ☐ No

2. Reported abnormalities/dysfunctions/problems of:

Liver?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
Heart?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
Kidneys?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
Lungs?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
Skin infections?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
Diabetes?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
TB?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
Head trauma?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___
Epilepsy/convulsions?	Yes___No___	If Yes, currently being treated by physician?	Yes___No___

3. [Are identified physical health conditions sufficiently stable to allow participation in outpatient treatment?] **(interviewer only)** ☐ Yes ☐ No ☐ N/A

4. [Any chronic health problems or disabilities?] **(interviewer only)** ☐ Yes ☐ No

5. Currently taking any prescribed medication for physical problems? (see Client Form A & B #33) ☐ Yes ☐ No

Notes:

_____

_____

Multnomah Clinical Assessment	Client's Name:

Dimension 3. Emotional/Behavioral Conditions & Complications

If using Client Form B, see Psychological History

1. Previous counseling or psychiatric treatment for problems other than alcohol/drug addiction? ☐ Yes ☐ No

   If yes, drinking/using during treatment? ☐ Yes ☐ No

   Date(s) and length of treatments _____

2. Is there a mental health diagnosis? ☐ Yes ☐ No

   If yes, what is it? _____

3. Have you ever taken any psychiatric medication? ☐ Yes ☐ No

   If yes, list name(s) and date(s) taken. _____

4. In the past 12 months, have any of the following caused you stress? (Check all that apply)

   ☐ a. Serious financial problems?
   ☐ b. Unemployment?
   ☐ c. Job loss/Job change?
   ☐ d. Job Problems?
   ☐ e. Homelessness/Inadequate housing?
   ☐ f. Inadequate/Lack of health care?
   ☐ g. Serious problems at home?
   ☐ h. Death of a family member?
   ☐ i. Death of a close friend?
   ☐ j. Separation or divorce?
   ☐ k. Serious illness or injury?
   ☐ l. Serious illness or injury to close friend/family member?
   ☐ m. Arrest or victim of a crime?

			If yes, substance use-related?		
5. Recent/threatened losses? (See #4)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
6. Recent major life changes:(See #4)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
7. History of chronic depression?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
8. Difficulty coping with daily life?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
9. Withdrawal from others?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
10. Change in eating/sleeping patterns?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
11. History of binging/purging, overeating, starving?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
12. Acute anxiety?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
13. Paranoia/ Hallucinations/ Delusions?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
14. Confused thinking/behavior?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
15. History of violent thoughts/ behavior?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both

Continued next page

WES 1a-8

Multnomah Clinical Assessment	Client's Name:

Continued from previous page

16. Current thoughts of harming others?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
17. Prior suicide attempts?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
18. Thinking or talking about suicide?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both

19. Have you ever been:
    a. emotionally abused (e.g., threatened, called names)?
       If yes, by whom? _____
    b. physically abused (e.g., pushed, shoved, hit, kicked)?
       If yes, by whom? _____
    c. sexually abused?
       If yes, by whom? _____

20. [History of physical/ sexual/ emotional abuse?] (Interviewer only)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Both
	☐ Deferred* (*Note: if deferred, inquiry should be attempted prior to completion of treatment plan.)				

Notes:

_____

_____

_____

_____

Multnomah Clinical Assessment	Client's Name:

Dimension 4. Treatment Acceptance / Resistance

1. External pressures or mandates?

			NAME	PHONE
SCF/CSD?	☐ Yes	☐ No		
JOBS/AFS?	☐ Yes	☐ No		
Employer?	☐ Yes	☐ No		
Spouse/Significant Other?	☐ Yes	☐ No		
Criminal Justice System?	☐ Yes	☐ No		

If YES, must complete "Criminal Justice System" questions

SSI?	☐ Yes	☐ No		
Family?	☐ Yes	☐ No		
Housing Requirement?	☐ Yes	☐ No		
Attorney?	☐ Yes	☐ No		
Probation Officer?	☐ Yes	☐ No		
Current treatment provider?	☐ Yes	☐ No		
Therapist?	☐ Yes	☐ No		

If using Client Form B, see Drinking and Other Drugs

2. [Acceptance of need for alcohol/drug treatment?] **(interviewer only)** ☐ Yes ☐ No

3. [Acknowledgement of the severity of alcohol drug problems?] **(interviewer only)** ☐ Yes ☐ No

Notes:

WES 1a-10

Multnomah Clinical Assessment	Client's Name:

Additional Questions for Criminal Justice Clients

Current offense(s)_____ Date_____

Were you under the influence of alcohol or drugs at the time of your arrest? ☐ Yes ☐ No

Are you a member of a gang? What gang?_____ ☐ Yes ☐ No

Do you have any special probation or court conditions regarding treatment? ☐ Yes ☐ No

If yes, what are the conditions?_____

What is your level of supervision?_____Low _____Medium _____High

Has your use been tied to other behaviors for which you have been convicted? ☐ Yes ☐ No

Is there a family history of addiction? ☐ Yes ☐ No

Is there a family history of criminality? ☐ Yes ☐ No

Total time incarcerated in adult life: ___Never ___Less than 25% ___25-50%
___More than 50% ___More than 75%

Do you have a history of probation/parole violations? ☐ Yes ☐ No
If yes, how many?_____

Have you ever been arrested AND charged with:

1. Shoplifting/Vandalism ☐ No ☐ Yes If yes, give dates:_____
   Were you convicted? ☐ Yes ☐ No
   Alcohol/drug related? ☐ Yes ☐ No
2. Parole/Probation violation ☐ No ☐ Yes If yes, give dates:_____
   Were you convicted? ☐ Yes ☐ No
   Alcohol/drug related? ☐ Yes ☐ No
3. Drug charges ☐ No ☐ Yes If yes, give dates:_____
   Were you convicted? ☐ Yes ☐ No
   Alcohol/drug related? ☐ Yes ☐ No
4. Forgery ☐ No ☐ Yes If yes, give dates:_____
   Were you convicted? ☐ Yes ☐ No
   Alcohol/drug related? ☐ Yes ☐ No
5. Weapons offense ☐ No ☐ Yes If yes, give dates:_____
   Were you convicted? ☐ Yes ☐ No
   Alcohol/drug related? ☐ Yes ☐ No
6. Burglary, larceny, B & E ☐ No ☐ Yes If yes, give dates:_____
   Were you convicted? ☐ Yes ☐ No
   Alcohol/drug related? ☐ Yes ☐ No
7. Robbery ☐ No ☐ Yes If yes, give dates:_____
   Were you convicted? ☐ Yes ☐ No
   Alcohol/drug related? ☐ Yes ☐ No

Multnomah Clinical Assessment	Client's Name:

8. Assault/Battery	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	
9. Arson	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	
10. Rape	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	
11. Homicide/Manslaughter	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	
12. Prostitution	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	
13. Contempt of court	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	
14. Domestic violence	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	
15. Other—specify: _____	☐ No	☐ Yes	If yes, give dates:_____			
			Were you convicted?	☐ Yes	☐ No	
			Alcohol/drug related?	☐ Yes	☐ No	

Do you have a history of conviction for the following offenses?

	Yes	No	Dates
Crimes against persons? How many?___?	☐	☐	_____
Crimes involving domestic violence? How many?___	☐	☐	_____
Any restraining orders? Current? ___	☐	☐	_____
Crimes against property? How many?___	☐	☐	_____
Drug & alcohol offenses? How many?___	☐	☐	_____

FOR ADJUDICATED CLIENTS ONLY:

Age of first incarceration _____

Date of most recent period of incarceration _____

Longest period of incarceration When? _____

For what? _____

Have you ever been convicted of a crime that resulted from your efforts to get money to support your habit? ☐ Yes ☐ No

WES 1a-12

Multnomah Clinical Assessment	Client's Name:

Dimension 5. Relapse Potential

If using Client Form B, see Previous Treatment

1. Prior alcohol/drug treatment history

   a. Detox ☐ Yes ☐ No
   If YES, number of times? _____
   Dates and Length of stay? _____
   Number of episodes completed? _____
   Reason(s) treatment not completed? _____

   b. Outpatient ☐ Yes ☐ No
   If YES, number of times? _____
   Dates and Length of stay? _____
   Number of episodes completed? _____
   Reason(s) treatment not completed? _____

   c. Residential ☐ Yes ☐ No
   If YES, number of times? _____
   Where? _____
   Dates and Length of stay? _____
   Number of episodes completed? _____
   Reason(s) treatment not completed? _____
   Total number of prior admissions? _____

2. Prior participation in 12-step Program(s)? (A.A., N.A.,et al) ☐ Yes ☐ No
   If YES, how long? _____

3. Awareness of relapse triggers? ☐ Yes ☐ No ☐ N/A

4. Have you ever been/are you currently involved in any other mandated treatment (i.e., anger management, sex offender, parenting)? ☐ Yes ☐ No
   If so, what? _____

See also Dimensions 1 and 6

Notes:

_____

_____

_____

_____

Multnomah Clinical Assessment	Client's Name:

Dimension 6. Recovery Environment

1. Current sources of support for abstinence and recovery?

Spouse/Significant Other?	Supportive___	Not Supportive___	Not Applicable___
Family?	Supportive___	Not Supportive___	Not Applicable___
Employer?	Supportive___	Not Supportive___	Not Applicable___
Self-help group?	Supportive___	Not Supportive___	Not Applicable___
Church?	Supportive___	Not Supportive___	Not Applicable___
Friends?	Supportive___	Not Supportive___	Not Applicable___
Other therapeutic involvement?	Supportive___	Not Supportive___	Not Applicable___

2. Is living arrangement supportive of abstinence and recovery? ☐ Yes ☐ No

3. Employed outside the home? (see Client Form A&B Employment History) ☐ Yes ☐ No

4. [Sees current education/employment level as an impediment to her/his recovery?] **(interviewer only)** ☐ Yes ☐ No

5. Any impediments/barriers to accessing treatment?

Distance?	☐ Yes	☐ No
Mobility impairment?	☐ Yes	☐ No
Childcare responsibility?	☐ Yes	☐ No
Transportation?	☐ Yes	☐ No
Literacy issues?	☐ Yes	☐ No
Housing?	☐ Yes	☐ No
Financial?	☐ Yes	☐ No
Language?	☐ Yes	☐ No

6. [Are there any indicators of risk to personal or public safety with continued alcohol/other drugs use while engaged in occupation?] **(interviewer only)** ☐ Yes ☐ No

7. Are there racial/ethnic background issues which will impact treatment? ☐ Yes ☐ No

8. Are there religious/spiritual issues which will impact treatment? ☐ Yes ☐ No

Notes:

_____

_____

_____

_____

WES 1a-14

Multnomah Clinical Assessment	Client's Name:

Asked of all clients

List all biological children, stepchildren, and other children:

Child's Name	Birth date	Sex	With whom is this child living?	Custody Status *	Support ordered? (Y or N)	Amount ordered	Current w/ pymt? (Y or N)	Balance

Clinical Referral Summary (cont.)

Client Name:_____ **Date:**_____

DUII only:

Case Number_____ ☐ Diversion ☐ Conviction

Petition Termination Date_____ Date of Offense_____ Conviction Date_____

Name of Judge_____ Name of P.O._____

Initial Clinical Impressions and Treatment Recommendations:

Referred To: _____

_____

OHP Number _____ OHP Plan _____

_____ _____

Alcohol and Drug Evaluation Specialist (signature) Date

WES. 1a-16

Clinical Referral Summary

Client Name:_____ **Date:**_____

Initial DSM-IV Diagnostic Impression:

Substance Use Disorder	Code	Course Specifier	Physiological Dependence	Route of Administration (1=oral, 2=smoking, 3=inhalation, 4=intramuscular injection, 5=intravenous injection, 6=other)
1. _____			with _____ without _____	
2. _____			with _____ without _____	
3. _____			with _____ without _____	
4. _____			with _____ without _____	

Clinician's Impression:

Client's self-concept: (poor) 1 2 3 4 5 6 7 (good)

Client's level of chemical dependency awareness: (poor) 1 2 3 4 5 6 7 (good)

Client's motivation for treatment: (poor) 1 2 3 4 5 6 7 (good)

Client's state in the addictive process: pre early middle late

Barriers to treatment:

- ☐ none
- ☐ spouse/partner
- ☐ money
- ☐ denial
- ☐ childcare
- ☐ other:_____
- ☐ family
- ☐ health
- ☐ transportation
- ☐ rationalization
- ☐ mental health
- ☐ school/work schedule
- ☐ literacy levels
- ☐ minimizing
- ☐ age
- ☐ cultural images

Placement Criteria (Circle a level for each dimension):

	Dimension	Level of Criteria			
1.	Detox/Withdrawal	I	II	III	IV
2.	Physical Health	I	II	III	IV
3.	Emotional Condition	I	II	III	IV
4.	Treatment Acceptance	I	II	III	
5.	Relapse Potential	I	II	III	
6.	Recovery Environment	I	II	III	

Decision Summary (Circle one):

Level I: 5 of 6 Dimensions meet Level I criteria
Level II: 2 of Dimensions 4, 5, or 6 meet Level II criteria. Dimensions 1, 2, and 3 are no greater than Level II
Level III: 3 of 6 Dimensions meet Level III criteria
Level IV: 1 of Dimensions 1, 2, or 3 meet Level IV criteria

Multnomah Clinical Assessment Placement Criteria: Decision Summary

Client's Name_____ **Date**_____

Dimensions:	1. Detox/Withdrawal	2. Physical Health Conditions and Complications	3. Emotional/Behavioral Conditions and Complications
Level I Outpatient Treatment	MUST MEET ONE OF THE FOLLOWING: ❑ Minimal or no risk of withdrawal ❑ Withdrawal symptoms with minimal risk of severe withdrawal syndrome. Patient and support person understand withdrawal care instructions. ❑ Adequate support services available to complete detoxification and treatment	MUST MEET ONE OF THE FOLLOWING: ❑ Any physical health conditions are sufficiently stable to permit participation in treatment ❑ Physical health conditions require ongoing care that can be provided in coordination with the outpatient program	MUST MEET ALL OF THE FOLLOWING: ❑ Emotional/behavioral conditions are mild enough not to interfere with treatment ❑ Coexisting emotional/behavioral conditions are being addressed by appropriate additional services ❑ Able to maintain emotional/behavioral stability in order to respond to treatment program ❑ Not at risk of harming self or others*
Level II Intensive Outpatient	MUST MEET ONE OF THE FOLLOWING: ❑ Minimal or no risk of withdrawal ❑ If exhibiting withdrawal symptoms, there is medical clearance. Patient and support person understand withdrawal care instructions. ❑ Adequate support services available to complete detoxification and treatment	MUST MEET ONE OF THE FOLLOWING: ❑ Any physical health conditions are sufficiently stable to permit participation in outpatient treatment ❑ Physical health conditions require ongoing care that can be provided in coordination with the outpatient program	MUST MEET ONE OF THE FOLLOWING: ❑ Lacks ability to maintain emotional/behavioral stability over a 72-hour period ❑ Risk of further abuse/neglect of spouse/children/ significant others* ❑ Coexisting emotional/behavioral conditions are being addressed by appropriate additional services ❑ Mild risk of endangering self or others* (homicidal, suicidal thoughts, no plans)
Level III Residential	MUST MEET ONE OF THE FOLLOWING: ❑ Risk or presence of withdrawal noted but manageable in this setting with medical clearance ❑ Previous history of non-entry into treatment following detoxification ❑ Continued use of non-prescribed mind-altering substances during detoxification at a less intensive level of care	MUST MEET THE FOLLOWING: ❑ Risk of any alcohol/other drug use places the patient in imminent danger of serious damage to physical health because of pre-existing conditions	MUST MEET ONE OF THE FOLLOWING: ❑ Coexisting emotional/behavioral conditions interfering with abstinence; requires continuous intervention ❑ History or presence of violent behavior during intoxication ❑ Moderate risk of endangering self or others*; increase in thoughts of homicide/suicide with non-lethal plans ❑ Stress reactions to recent/threatened losses prevent response to treatment
Level IV Medically Managed	MUST MEET ONE OF THE FOLLOWING: ❑ Risk or presence of severe withdrawal syndrome ❑ Detoxification during pregnancy	MUST MEET ONE OF THE FOLLOWING: ❑ Physical complications of addiction requiring medical management ❑ Physical illness or pregnancy needing stabilization requiring medical management	MUST MEET ONE OF THE FOLLOWING: ❑ Coexisting emotional/behavioral conditions have complications requiring medical management ❑ Uncontrolled behavior endangering self or others*; homicidal/suicidal thoughts and lethal or attainable plans ❑ Mental confusion, fluctuating orientation, thought process impairment that is so severe that client cannot care for self (ADLs) ❑ Alcohol/other drug use gravely complicates previously diagnosed psychiatric or emotional/ behavioral condition

* includes the fetus

WES 1a-

Multnomah Clinical Assessment Placement Criteria: Decision Summary

WES-1a-18

Client's Name_____ **Date**_____

Dimensions:	4. Treatment Acceptance/Resistance	5. Relapse Potential	6. Recovery Environment
Level I Outpatient Treatment	MUST MEET BOTH OF THE FOLLOWING: ❑ Agreement to cooperate and attend all scheduled activities ❑ Even with admission of an alcohol/other drug problem, monitoring and motivating strategies are needed	MUST MEET THE FOLLOWING: ❑ Scheduled therapeutic contacts are necessary to maintain recovery goals	MUST MEET ONE OF THE FOLLOWING: ❑ A supportive environment exists for recovery ❑ Demonstrated motivation and willingness to obtain adequate support system ❑ Professional interventions required for family/ significant others and patient in order to improve chances of success
Level II Intensive Outpatient	MUST MEET BOTH OF THE FOLLOWING: ❑ Tendency to attribute alcohol/other drug problems to external events/people ❑ Agreement to participate; history of non-completion of immediate lower level of care	MUST MEET ONE OF THE FOLLOWING: ❑ Inability to maintain recovery goals despite participation in a less intensive level of care ❑ Significantly lacks awareness of relapse potential, with much difficulty postponing gratification	MUST MEET THE FOLLOWING: ❑ Ability to meet recovery goals unlikely in current work, family, or social environment
Level III Residential	MUST MEET THE FOLLOWING: ❑ Non-acceptance or resistance to severity of the problem despite serious adverse consequences/ effects on health, family, work, or social life	MUST MEET ONE OF THE FOLLOWING: ❑ Acute crisis with imminent danger of continued substance use with severe consequences ❑ History of inability to reduce use of alcohol/ other drugs, despite acknowledging severe consequences, and repeated attempts to do so ❑ The structure and relate protocols to address relapse issues can only occur at this level	MUST MEET ONE OF THE FOLLOWING: ❑ Removal from a volatile and/or non-supportive living environment is necessary to allow stabilization and recovery skill development ❑ Logistic impediments preclude accessing treatment at a lower level of care, e.g., distance, mobility impairments, transportation ❑ Danger of physical, sexual, or severe emotional victimization exists ❑ Risk to personal or public safety with continued alcohol/other drug use while working
Level IV Medically Managed	ADMISSION TO THIS LEVEL. MUST MEET DIMENSIONS 1,2 OR 3	ADMISSION TO THIS LEVEL MUST MEET DIMENSIONS 1,2 OR 3	ADMISSION TO THIS LEVEL MUST MEET DIMENSIONS 1,2 OR 3

Wes 1b

Multnomah Clinical Assessment

Multnomah County, Oregon

Client Form B

Full Name_____

Date _____

If you have any problems with reading or writing please ask for help.

SID#	DCC Client ID

Evaluator's Name:_____

Client Name: _____

General Information

- 1. What was your last name at birth? _____
- 2. Sex: ☐ Male ☐ Female
- 3. Date of birth (mm/dd/yy): _____ Age: _____

  • Evaluator Use Only ☐ Known ☐ Estimated

- 4. What other names have you used (a.k.a.)? _____
- 5. You are:

  ☐ 01- White (non-Hispanic) ☐ 05- Asian or Pacific Islander ☐ 09- Other Hispanic
  ☐ 02- Black (non-Hispanic) ☐ 06- Hispanic-Mexican ☐ 10- Southeast Asian
  ☐ 03- Native American ☐ 07- Hispanic-Puerto Rican ☐ 11- Other Race
  ☐ 04- Alaskan Native ☐ 08- Hispanic-Cuban

6. Do you speak English at home? ☐ Yes ☐ No
7. Do you speak another language? ☐ Yes ☐ No If yes, specify: _____

   • Evaluator Use Only Interpreter: ☐ Foreign Language ☐ Hearing impaired ☐ No

8. Current address: _____ Street
   ☐ None
   _____ City State Zip
- 9. In what county do you live? _____
10. How long have you lived at this address? Months _____ Years _____
- 11. Address (where you receive mail): _____ Street
   _____ City State Zip
- 12. Home phone: _____
- 13. Message phone: _____
14. Work phone: _____
15. Work hours: _____
16. Do you have a valid driver's license? ☐ Yes ☐ No
17. License #: _____ State: _____
18. Do you own an automobile? ☐ Yes ☐ No
19. Do you have valid car insurance? ☐ Yes ☐ No
20. Contact in case of emergency: _____ Name
   _____ Address _____ State Zip
   _____ Telephone _____ Relationship to you

WES 16-2

Client Name: _____

Military History

- 21. Are you a veteran? ☐ Yes ☐ No

22. Type of discharge? ☐ Honorable ☐ Dishonorable ☐ General

Medical Insurance

- 23. Please check the type of insurance you have, or check "None" if you do not have insurance:

☐ Oregon Health Plan ☐ Medicaid ☐ Private ☐ None
☐ Medicare ☐ VA ☐ Other public

- 24. What is the plan name? _____
- 25. What is the plan number? _____

26. Who referred you for an assessment? _____
Contact Name Agency

_____
Address Telephone

- Evaluator Use Only

☐ Assessment ☐ Screening	☐ Walk in ☐ Phone
Referral source 1: (see back of data sheet)	Referral source 2: (see back of data sheet)

Medical History

27. Names of doctor(s): Telephone:

_____ _____

_____ _____

28. List any medications you are taking:

Name	How much	How often	Prescribed by whom

29. When was the last time you received any type of health care (emergency room, hospitalization, doctor visit)? _____/_____/_____

30. What for? _____

(Skip to #36 if you are male.)

Women Only:

- 31. Are you pregnant? ☐ Yes ☐ No

32. If yes, when is the baby due? _____/_____/_____

33. If yes, are you getting prenatal care? ☐ Yes ☐ No

Client Name: _____

- 34. Have you been pregnant in the last 12 months? ☐ Yes ☐ No

35. Check any of the problems you have had:

☐ Pelvic inflammatory disease
☐ Painful sex/intercourse
☐ Problems with PMS or menopause
☐ Periods: Irregular, painful, heavy bleeding

- 36. Do you get a pension for a physical (not mental) disability? ☐ Yes ☐ No

Education History

- 37. What is the highest grade you have completed? (0 thru 25)_____
- 38. Do you have a high school diploma or GED? ☐ Yes ☐ No
- 39. Are you now enrolled in school or training? ☐ Yes ☐ No

Employment History and Financial Status

- 40. Please check your work situation now:

☐ 1- Full time (35 hours or more)
☐ 2- Part-time (17 - 34 hours)
☐ 3- Irregular (less than 17 hours)
☐ 4- Not working and looking for work
☐ 5- Not working and not looking for work (retired, student, disabled)

(Skip to # 42 if you checked either #4 or #5)

41. Employer (optional):

_____
Employer

_____
Address Telephone

_____
Your position

42. How much money do you make in a month? _____

43. Longest period of continuous employment in adult life?_____

44. How long has it been since you were last employed?

☐ 12 months
☐ 24 months
☐ 36 months
☐ Never been legally employed
☐ 48 months
☐ 60 months
☐ More than 5 years

- 45. Please check your primary source of household income:

☐ Wages/salary
☐ Social Security
☐ SSI Federal
☐ OSIP - State
☐ Public Assistance/Welfare
☐ Dividends/Interest
☐ Pension
☐ Unemployment
☐ Veterans
☐ Alimony/Child Support
☐ Other
☐ None

46. Do you receive food stamps? ☐ Yes ☐ No

- 47. What is your total monthly household income? _____ Refused ☐

WES 16-4

Client Name: _____

- 48. In each age group listed, enter the total number of people that depend on this household income, including yourself:

  _____ Ages 0-5 _____ Ages 6-17 _____ Ages 18-64 _____ Ages 65 +

- 49. Please check the box that describes your employment situation now:

  ☐ 0- Able to work or working now
  ☐ 1- Student
  ☐ 2- Homemaker
  ☐ 3- Retired
  ☐ 4- Unable to work for physical or psychological reasons
  ☐ 5- Incarcerated
  ☐ 6- Seasonal worker
  ☐ 7- Temporary layoff

Family and Interpersonal History

- 50. Current relationship status:

  ☐ 1- Never married
  ☐ 2- Married
  ☐ 3- Widowed
  ☐ 4- Divorced
  ☐ 5- Separated
  ☐ 6- Living as married

51. Some programs have specialized treatment based on sexual orientation. For this purpose, how do you identify yourself?

  ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual

- 52. What is your current living situation?

  ☐ 01- In my own home/apartment
  ☐ 23- In my spouse's/partner's home
  ☐ 03- In relatives'/adult children's home
  ☐ 04- In a foster home
  ☐ 05- In an institution/group home/ cooperative housing
  ☐ 06- In a friend's home
  ☐ 97- In a shelter/ homeless
  ☐ 98- Unknown

53. Do you live in Section 8 or subsidized housing? ☐ Yes ☐ No

- Evaluator Use Only

☐ Independent	☐ Dependent	☐ Homeless	☐ Public Housing

Living Arrangement Definitions

Independent: Includes single unit housing such as hotels, SRO room, apartments or houses. Does not include supervised settings or public assisted housing.

Homeless: No fixed address (includes shelters).

Dependent: Includes dependent adults and children living in a supervised setting (such as halfway or group homes).

Public Housing: Housing assisted or supported by government funds.

Legal History

- 54. Number of times arrested in your lifetime? _____
- 55. Number of times arrested in last 2 years? _____
- 56. Number of times arrested for DUII in the past 5 years? _____
- 57. Are you on probation or parole? ☐ Yes ☐ No

  If yes, to whom do you report? _____

58. What is your current involvement with the criminal justice system?

  ☐ Pretrial
  ☐ Presentence
  ☐ Bench probation
  ☐ Formal probation
  ☐ Drug court/STOP program
  ☐ Formal parole

Client Name: _____

59. Do you have a history of conviction for the following offenses?

	Dates of Offenses
DUII, Driving while suspended, etc.	_____
Drug charges	_____
Forgery or larceny	_____
Burglary or Robbery	_____
Domestic Violence, Assault	_____
Weapons charges	_____
Manslaughter, homicide	_____
Other charges	_____

60. In the last 6 months has your urine or blood been tested for alcohol or other drug use? ☐ Yes ☐ No

61. Who tested you? _____

62. What were the test results? _____

63. How much time have you spent in your life incarcerated? _____

64. How long was your last incarceration? _____

65. Why were you incarcerated? _____

66. What was your longest period of incarceration? _____

WES 16-6

Client Name: _____

Alcohol Use Questionnaire

1. How old were you when you had your first drink? _____
2. Do you drink more now to get the same effect? (1D) ☐ Yes ☐ No
   Do you drink less now to get the same effect? (1D) ☐ Yes ☐ No
3. When did you last have a drink? _____
4. How many drinks do you usually have each time you drink? _____
5. In the last 30 days, how many days did you drink? _____
6. Has there been a time in your life when you drank daily? ☐ Yes ☐ No

   For how long? _____ (3D) When was that? _____
7. Have you cut down on your drinking since your DUII arrest? (4D) ☐ Yes ☐ No
8. Are you able to stop drinking when you want to? (4D) ☐ Yes ☐ No
9. Where do you do most of your drinking? ☐ Alone ☐ With others?
10. Can you stop drinking without a struggle? (4D) ☐ Yes ☐ No
11. Have you gotten into trouble at work or school because of drinking? (6D) ☐ Yes ☐ No
12. Have you ever neglected your responsibilities to yourself or your family because of drinking?(6D) ☐ Yes ☐ No
13. Has your drinking caused you to lose a job? (6D) ☐ Yes ☐ No
14. Has there been a time when you drank in larger amounts or for longer periods than you intended? (3D) ☐ Yes ☐ No
15. Have you missed work or school (or taken sick leave) because of drinking? (6D) ☐ Yes ☐ No
16. Have you awakened in the morning after drinking the night before and found that you could not remember a part of the evening before? ☐ Yes ☐ No
17. Have you ever passed out when drinking? ☐ Yes ☐ No
18. Do you ever have a drink the "morning after" to get rid of a hangover? (2D) ☐ Yes ☐ No
19. Have you ever been told that you have liver trouble or cirrhosis? (7D) ☐ Yes ☐ No
20. Have you ever had delirium tremens (D.T.'s), hands shaking, heard voices, or seen things that were not there after heavy drinking? (2D) ☐ Yes ☐ No

Client Name: _____

21. Would you like assistance with drinking problems at this time?	☐ Yes	☐ No
22. Have you ever gone to anyone for help about your drinking?	☐ Yes	☐ No
23. Have you ever been in a hospital because of drinking?(6D)	☐ Yes	☐ No
24. Have you ever been prescribed Antabuse?	☐ Yes	☐ No
25. Have you continued to drink when you knew you had a physical illness that might be made worse by drinking?	☐ Yes	☐ No
26. Have you, your physician, or someone else, thought you were having physical problems due to drinking?	☐ Yes	☐ No
27. Do you have any relative that has or had a drinking problem?	☐ Yes	☐ No

What relative is it? _____

WES 16-8

Client Name: _____

Drug Use Questionnaire

1. How old were you the first time you used or tried any drug? _____
2. Have you used drugs in the last 30 days? ☐ Yes ☐ No
3. What drugs do you use?

	Age of First Use	Age of Last Use
Marijuana		
Cocaine		
Crack Cocaine		
Amphetamines		
Methamphetamines		
Heroin		
Other Opiates		
Hallucinogens		
Non-Prescription Methadone		
Barbiturates		
Other sedatives or hypnotics		
Inhalants		
Over-the-counter		
Tranquilizers		
Other Drugs		
PCP (Angel Dust)		

For each drug used, please answer the following questions:

4. Which drugs do you use daily? _____

   Weekly? _____

   Monthly? _____

   When did you last use? _____

   How many days in the past 30 days have you used drugs? _____

   Which drugs? _____

   Do you need more of the drug to get the same effect? ☐ Yes ☐ No

   Which drugs? _____

   Which drug do you like to use the most? _____

Client Name: _____

5. Has there been a time when you used drugs in larger amounts and/or for longer than intended? (3D) ☐ Yes ☐ No

6. Have you been arrested for possession, manufacture, distribution, etc? ☐ Yes ☐ No

   Which drugs? _____

7. Have you cut down on your drug use since your arrest? ☐ Yes ☐ No

8. Are you able to stop using drugs when you want to? (4D) ☐ Yes ☐ No

9. Where do you do most of your drugging? ☐ At home ☐ Away from home

10. Can you stop using drugs without a struggle? (4D) ☐ Yes ☐ No

11. Has your drug use ever caused you to lose a job? (6D) ☐ Yes ☐ No

12. Have you gotten into trouble at work or school because of drug use? (6D) ☐ Yes ☐ No

13. Have you ever neglected your responsibilities to yourself or your family because of drug use? (6D) ☐ Yes ☐ No

14. Have you had withdrawal symptoms when stopping the drug and/or have you used to avoid withdrawal? (2D) ☐ Yes ☐ No

15. Have you continued to use a drug/drugs when you were physically ill? (7D) ☐ Yes ☐ No

    Have you, your physician, or someone else, thought you were having physical problems because of your drug use? ☐ Yes ☐ No

16. Would you like assistance with drug problems now? ☐ Yes ☐ No

WES 16-10

Client Name: _____

Drinking and Other Drugs

1. People drink and/or use other drugs for different reasons. How important would you say that each of the following is to you as a reason for drinking or using? (Put a check mark for each item.)

	Very Important	Fairly Important	Not at all Important
A. To help me relax.	_____	_____	_____
B. To be sociable.	_____	_____	_____
C. I like the taste of alcohol.	_____	_____	_____
D. Because other people I know do it.	_____	_____	_____
E. When I get angry.	_____	_____	_____
F. When I want to forget everything.	_____	_____	_____
G. To celebrate special occasions.	_____	_____	_____
H. To forget my worries	_____	_____	_____
I. To improve my appetite.	_____	_____	_____
J. To be polite.	_____	_____	_____
K. To cheer myself up.	_____	_____	_____
L. When I am tense and nervous.	_____	_____	_____
M. To feel normal.	_____	_____	_____
N. Other (specify): _____	_____	_____	_____

2. Have you gotten into fights after drinking or using drugs? ☐ Yes ☐ No

3. Drinking and using other drugs affects people in different ways. Check those that apply to you.

   ☐ I become physically abusive (hit or push or slap, etc. others).
   ☐ I become undependable.
   ☐ I become quarrelsome.
   ☐ Other (specify):

4. Check any of the following if they apply to how your friends and family feel about your alcohol and other drug use.

   ☐ My family and friends worry about me.
   ☐ My family and friends complain about my drinking/using.
   ☐ I have problems with my girl friend, boy friend, spouse.
   ☐ My friends and family have gone to others for help about my drinking and/or using.
   ☐ My drinking and/or using has damaged my relationship with family and/or friends.

5. Do you consider yourself to have a potential problem with alcohol? ☐ Yes ☐ No

6. Do you consider yourself to have a potential problem with drugs? ☐ Yes ☐ No

7. Do you consider yourself to be an alcoholic? ☐ Yes ☐ No

8. Do you consider yourself to be a drug addict? ☐ Yes ☐ No

Client Name: _____

9. Which is your main problem? ☐ Alcohol ☐ Drugs ☐ Both

Psychological History

1. Please check those that apply.

☐ Depression
☐ Suicidal Thoughts
☐ Self harm/suicide attempt(s)
☐ Withdrawn/isolated
☐ Crying spells
☐ Anger control
☐ Appetite/weight changes
☐ Sleep changes
☐ Loneliness
☐ Hallucinations
☐ Paranoia
☐ Anxiety

2. Do you have any history of mental illness or psychiatric hospitalization for yourself or any of your family members? ☐ Yes ☐ No

   If yes, who and when? _____

3. Have you had any mental health counseling? ☐ Yes ☐ No

   If yes where and when and what kind? _____

4. Have you ever been prescribed medicine for any emotional problem? ☐ Yes ☐ No

   If yes, what medicine? _____

   Who prescribed it?
   Did it help? ☐ Yes ☐ No

5. Have you ever been emotionally abused (yelled at, threatened, called names)? ☐ Yes ☐ No

   If yes, by whom? _____

6. Have you ever been physically abused (pushed, hit, slapped)? ☐ Yes ☐ No

   If yes, by whom? _____

7. Have you ever been sexually abused? ☐ Yes ☐ No

   If yes, by whom? _____

History of Previous Treatment

1. How many times have you been in residential treatment for alcohol/drugs? _____

2. How many times have you been in treatment as a result of a DUII? _____

3. How many times have you been in outpatient treatment for alcohol/drugs? _____

WES 16-12

Client Name: _____

4. How many times have you been in detox? _____

5. What is the total number of times you have been in all types of treatment? _____

6. Have you ever attended AA (Alcoholics Anonymous), NA (Narcotics Anonymous) or other 12 step meetings? ☐ Yes ☐ No

   If yes, why did you go? _____

   Do you have a sponsor? ☐ Yes ☐ No

   Have you had a sponsor? ☐ Yes ☐ No

   Have you worked the 12 steps? ☐ Yes ☐ No

7. How many times have you overdosed on drugs? _____

   When was the last time? _____

8. What is the longest period of time you have stayed clean and sober? (months or years) _____

Gambling

1. Do you gamble? ☐ Yes ☐ No

2. How much do you spend each week on gambling? _____

3. Have you made repeated, unsuccessful efforts to control, cut back or stop gambling? ☐ Yes ☐ No

4. How many days in the past 30 have you gambled? _____

5. Have you been troubled or bothered by gambling problems in the past 30 days? ☐ Yes ☐ No

6. Would you like help with gambling problems? ☐ Yes ☐ No

Health Screen Inventory

1. How many times in your life have you been hospitalized for medical problems? (Do count overdoses and delerium tremens [Dts]. Don't count detox and births.) _____

2. How long ago was your last hospitalization for medical problem? Years _____ Months _____

3. Do you now have any chronic medical problems which continue to interfere with your life? ☐ Yes ☐ No

4. Are you taking any prescribed medication on a regular basis for a physical problem? ☐ Yes ☐ No

Client Name: _____

5. Do you have any kind of disability (mobility, learning, eyesight, hearing, developmental) or major limitation? ☐ Yes ☐ No

6. Have you ever had nerve problems (convulsions,epilepsy, shaking, migrains [exclude mental health problems])? ☐ Yes ☐ No

7. Have you ever had eating disorders (bulimia, anorexia, binging, or purging)? ☐ Yes ☐ No

8. Where do you usually receive health care?

☐ Physician (M.D.)
☐ Nurse practitioner
☐ Community health nurse
☐ Emergency room
☐ Indian Health Services
☐ Other (specify): _____
☐ None

9. Please check if you have any current medical problems:

☐ Liver
☐ Heart
☐ Kidneys
☐ Lungs
☐ Skin Infections
☐ Diabetes
☐ TB
☐ Head Trauma
☐ Epilepsy/Convulsions
☐ Other (specify) _____

10. How troubled or bothered have you been by these medical problems in the past 30 days?

☐ Not at all
☐ Slightly
☐ Moderately
☐ Considerably
☐ Extremely

11. How important to you now is additional treatment for these medical problems?

☐ Not at all
☐ Slightly
☐ Moderately
☐ Considerably
☐ Extremely

WES 1c

IRMA DATA SHEET
Supplemental Data

Field Name	Data (Write information or check choice)				
Client Name	Last:	First:		Middle:	
	Title (Sr., Jr., III):				
Date of Birth (mm-dd-yy)	(from Client Form, page 2)				
see codes on back (from Dimen. 1, pages 2.& 3)	Addiction types*	Frequency of use*	Route of Admin*	Age at first use	Days used in last 30 days
Primary Substance					
Secondary Substance					
Tertiary Substance					
Age of first drug use (excluding alcohol)	(from Dimen. 1, page 3)				
Physical Disease	☐ Yes ☐ No (from Dimen. 2, Question 4)				
Mental Disorder	☐ Yes ☐ No (from Dimen. 3, Question 2)				
Number prior admissions to substance abuse pgms	(from Dimen. 5, Question 1C)				
Assess Completion Date					
Length of Assessment					
Evaluator's Name					
Other Referrals Made (check all that apply)	☐ Education ☐ Family Services ☐ Employment ☐ Legal ☐ Housing ☐ Mental Health ☐ Health ☐ Spiritual ☐ Law Enforcement ☐ Other				
Referred to (CPMS List) *	1. 2.				
(REFERRAL)	☐ SDU Referral ☐ Non-SDU Referral				
Referral Date					
Provider/Resource & location					
Modality Classification*	(SDU only)				
DUII Treatment Level	☐ Education ☐ Rehabilitation ☐ None				
Date to contact agency					
Referral reason *	(SDU only)				
Wait list begin date	(SDU only)				
Availability date	(SDU only)				

* See codes on back

TER 3

CLINICAL STAFFING NOTE

CASEMANAGEMENT

PATIENT'S NAME _____ **DATE**_____

Summarize the general health status and special problems or concerns re: the patient (e.g., diabetes, hypertension, cardiac problems, allergies, nutrition/elimination difficulties):

_____

_____

_____

_____

_____

_____

Review of Medications (type, dosage, effectiveness side effects):

_____

_____

_____

_____

_____

Treatment Plan Review Identify each active problem by name and number. Note progress in terms of the specific objectives listed on the respective treatment plans. If the patient is not showing progress, note changes in objectives, assignments, and/or approach.

DATE: **STAFF:** _____ _____ _____ _____

PROBLEM #1 Eligibility Status **Homeless:**____ **Low Income:**____
Yr. Review:____ **Date:**

_____

Plan: _____

_____

_____

_____

Progress: _____

_____

Resolved:____ **Deferred**____ **Referred:**____ **Other:**_____

ISAL 32
FILE IN LAB SECTION

HCH DIAGNOSTIC TESTING FOLLOW-UP FORM

Date: _____

Client Date of Birth: _____ SS#: _____

Type of Diagnostic Test (circle one):

1. PAP Smear
   Date of Test _____
2. Mammogram
   Date of Test _____
3. Radiologic Procedure
   Date of Test _____
4. Other Testing Procedure
   Date of Test _____

PAP Smear Results (circle one):	Mammogram Results (circle one):	Other Lab/X-ray, etc.
1. Normal	1. Normal	
2. Abnormal	2. Abnormal	
PAP Smear Follow-up Note:	**Mammogram Follow-up Note:**	
1. Repeat PAP ASAP	1. Repeat ASAP	
2. Repeat PAP 6 months	2. Repeat 6 months	
3. Refer to GYN	3. Repeat 1 year	
4. Repeat in 1 Year	4. Refer to Surgery	

Tracking (circle method used):	Other Follow-up/Plan of Care:
1. Abnormal Lab Letter Sent	
2. E-mail sent to HCH providers	
3. Other:_____	

Provider Signature _____ Date _____

CLIENT LAST NAME:		FIRST:		HCH#:	

WES 9

CONFIDENTIAL FAMILY PLANNING HISTORY

Adult Health History Form Must be Completed at Least Once

Current History (To be completed by client)

How old were you when your periods started?
(menstruation) _____

When was the 1st day of your last period? _____
Do you have bleeding between periods? Yes ___ No ___

What kind of birth control do you use now?

_____

What kind of birth control have you used before?

_____

Have you ever had your tubes tied? Yes ___ No ___

Have you ever had chicken pox? Yes ___ No ___

Have you ever had 3-day measles? Yes ___ No ___

Are you breastfeeding now? Yes ___ No ___

Obstetrical History:

pregnancies _____
live births _____
miscarriages _____
abortions _____

History to be taken by provider

Do you have any:

vaginal discharge _____
pain with urination _____
pain with intercourse _____

1. Are you currently having sex with anyone?
Yes _____ No _____

2. When was the last time you had sex? _____

3. # partners since last PAP smear. _____

4. Have your sex partners been men, women, or both? (circle one)

5. Have you ever had a sexually transmitted disease such as genital warts, herpes, chlamydia, gonorrhea, syphilis, or HIV?
Yes ___ No ___ If yes, circle which one(s).

6. Have you ever been abused sexually or physically? Yes ___ No ___

If you were born before 1972 did your mother take DES when she was pregnant with you? Yes ___ No ___

CLIENT NAME _____
DATE OF BIRTH _____

FAMILY PLANNING PHYSICAL EXAM

**Minimal Title X Contraceptive Exam Requirements*

(To be completed by provider)

	N	Ab
*Thyroid Exam	_____	_____
**Breast Exam	_____	_____
Nodes	_____	_____
*Heart	_____	_____
*Lungs	_____	_____
*Peripheral veins	_____	_____
*Abdomen	_____	_____
**Genitalia:		
External	_____	_____
Vagina	_____	_____
Cervix	_____	_____
Uterus	_____	_____
Adnexa	_____	_____

** To be done at initial visit only.*
*** Annually if hormonal method of contraception.*

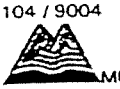
Significant physical findings (describe):

_____
_____
_____
_____
_____
_____
_____

LABS: *PAP ___ Preg Test ___
** Annually if IUD or hormonal method.*
GC ___ Hgb ___
CT ___ VDRL ___
UA ___ HIV ___

SEE PROGRESS NOTES FOR ASSESSMENT AND PLAN

EXAMINER : _____
DATE EXAMINED: _____



HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

FEVER (Child)

S:_____

_____

_____

O:_____

_____

_____

_____

A1 FEVER:_____

_____

A2 PROVIDED MEDICATION(s):_____

Instructed: never give aspirin to children

Assessed for allergies/contraindications

Reviewed importance of medication safety with children

Instructed parent(s) re: relief measures; increase fluids; avoid over-dressing; give tepid baths for fever 104o

Instructed re: use of thermometer and normal temperature range (97-99o) orally

Advised when to call MD or ER

Enrolled in HPHP

Advised to follow-up: Where: When:

_____

_____

P Client to initiate contact with HPHP as necessary for follow-up

_____

SIGNED_____ Page #_____

HPH 7

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

FUNGAL INFECTION OF FEET / FOOT

S:_____

_____

_____

O:_____

_____

_____

A1 FUNGAL INFECTION OF FEET / FOOT as evidenced by: itching, odor, cracking/splitting of skin_____

_____

_____

A2 PROVIDED MEDICATION(s):_____

Advised re: proper use; assessed for allergies; hypersensitive skin or other contraindications

Discussed etiology: fungus that lives in warm, moist, dark areas

Instructed re: measures to alleviate discomfort and avoid repeated infection: keep feet clean and dry; avoid unnecessary creams/lotions; launder socks frequently; don't share shoes/socks; avoid wading bare foot in communal shower facitlities. Air dry feet when weather permits. Use cotton socks during day, wear no socks at night.

Advised of available laundry facilities. Directed to best resource for clean socks/shoes; provided clean socks

Advised to seek medical attention should signs of infection persist or worsen

_____

_____

P Client to initiate contact with HPHP as necessary for follow-up

_____

SIGNED_____ Page #_____

HEALING HANDS HEALTH CARE SERVICES GYN Exam

NAME _____ AGE ____ SEX ____ RACE ____ Chart # _____

DRUG ALLERGIES & REACTIONS _____

DATE _____ **Patient Education Done** (Nurse Initial)

WT _____ Temp _____ BSE _____ Menopause _____

BP _____ Pulse _____ Contraception _____ HRT _____

STD _____ Healthy Lifestlye _____

S: LMP _____ LPS _____ Results _____ Mammogram _____ Results _____

Contraception _____ Parity _____

Past Hx _____

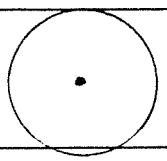
Current Hx _____

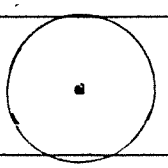
_____

_____

_____

O: Breast





	Left	**Right**
Skin	_____	_____
Masses	_____	_____
Areola/Nipple	_____	_____
Adenopathy	_____	_____

Pelvic

External genitalia _____

Vagina _____

Cervix _____

Uterus _____

Adnexa _____

Other _____

_____

A: _____

_____

P: _____

_____

_____

_____

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

HEAD LICE

S_____

_____

_____

O WHITE EGGS (NITS) FIRMLY ATTACHED TO HAIR SHAFT CLOSE TO SCALP/LIVE LICE

VISUALIZED:_____

_____

A1 HEAD LICE:_____

A2 ASSESSED FOR: PREGNANCY; PRIOR TX; CONTRAINDICATIONS

PROVIDED MEDICATION: Nix/_____

Instructed re: Proper use of Nix (cream rinse) after washing hair.

Advised to: Launder all clothing and bed sheets that have had contact with the scalp in hot washer and dryer. Dry clean or seal in plastic all non-washable items.

Advised to: Soak all combs, brushes, barrettes, hair ties, etc. in H20 with bleach for 30 minutes.

Advised to: Tx all contacts at the same time to prevent reinfection.

Advised: Successful Tx depends on thorough removal of all nits using the lice comb provided.

Advised: Lice don't fly or jump - they are transmitted person-to-person from personal items (caps,combs, etc.)

Advised: Lice are not carried nor transmitted by household pets.

_____

_____

P Client to initiate contact with HPHP as needed for follow-up

_____

SIGNED_____ Page #_____

BAL 6-1

HEALTH CARE FOR THE HOMELESS, INC.
HISTORY AND PHYSICAL FORM

DATE: _____

CLIENT NAME: _____ HCH NUMBER: _____

DATE OF BIRTH: _____ GENDER: _____

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS (DATE OF ONSET, SYMPTOMS, PRECIPITATING FACTORS, ETC.) _____

I. PATIENT'S USUAL SOURCE OF HEALTH CARE _____

II. PERCEIVED STATE OF HEALTH? HOW WOULD YOU DESCRIBE YOUR HEALTH? _____

III. **MEDICAL PROBLEMS: DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (CHECK NEXT TO ANSWER)**

HIGH BLOOD PRESSURE	YES[ ]	NO[ ]	YR. DX._____
HEART DISEASE	YES[ ]	NO[ ]	YR. DX._____
LUNG DISEASE	YES[ ]	NO[ ]	YR. DX._____
DIABETES	YES[ ]	NO[ ]	YR. DX._____
ANEMIA	YES[ ]	NO[ ]	YR. DX._____
THYROID DISEASE	YES[ ]	NO[ ]	YR. DX._____
STROKE	YES[ ]	NO[ ]	YR. DX._____
CANCER	YES[ ]	NO[ ]	YR. DX._____
"NERVE PROBLEMS" OR PSYCHIATRIC PROBLEM (INCLUDING DEPRESSION)	YES[ ]	NO[ ]	YR. DX._____
ARTHRITIS	YES[ ]	NO[ ]	YR. DX._____
GASTROINTESTINAL (STOMACH) PROBLEMS	YES[ ]	NO[ ]	YR. DX._____
GENITO-URINARY (KIDNEY OR BLADDER) PROBLEMS	YES[ ]	NO[ ]	YR. DX._____
SKIN DISORDERS	YES[ ]	NO[ ]	YR. DX._____
SEIZURES	YES[ ]	NO[ ]	YR. DX._____
ANY OTHER MEDICAL DIAGNOSIS WE HAVEN'T COVERED? (LIST)	YES[ ]	NO[ ]	YR. DX._____

IV. **OB/GYN**

		YES	NO	COMMENTS
A.	HAS THE PATIENT EVER BEEN PREGNANT	[ ]	[ ]	
B.	IF YES, HOW MANY: FULL-TERM PREGNANCIES:	____		
	PREMATURE BIRTHS	____		
	MISCARRIAGES OR ABORTIONS	____		
	LIVING CHILDREN	____		
C.	BEGINNING DATE OF LAST MENSTRUAL PERIOD	__/__/__		
D.	WAS LAST MENSTRUAL PERIOD NORMAL?	[ ]	[ ]	
E.	DOES THE PATIENT USE A BIRTH CONTROL METHOD	[ ]	[ ]	
F.	IF YES, SPECIFY			
G.	WHEN WAS LAST PAP TEST?	__/__/__		

V. PREVIOUS HOSPITALIZATIONS/SURGERIES/INJURIES

DATE	PROBLEM	PLACE

DAL 6-2

VI. VACCINATION HISTORY

		YES	NO	
A.	MEASLES, MUMPS, RUBELLA (MMR)	[ ]	[ ]	
B.	LAST TETANUS BOOSTER	[ ]	[ ]	__/__/__
C.	HEPATITIS B	[ ]	[ ]	
D.	PNEUMOVAX	[ ]	[ ]	

VII. TUBERCULOSIS HISTORY

		YES	NO
A.	ANY KNOWN EXPOSURE TO M.Tb?	[ ]	[ ]
B.	DATE OF LAST PPD	__/__/__	
C.	ANY HISTORY OF POSITIVE PPD?	[ ]	[ ]
D.	IF YES, WAS PROPHYLAXIS GIVEN?	[ ]	[ ]
E.	IF YES, DURATION AND TYPE	_____	

VIII. FAMILY HISTORY

		YES	NO	
A.	BLEEDING TENDENCY	[ ]	[ ]	_____
B.	CANCER (TYPE)	[ ]	[ ]	_____
C.	DIABETES	[ ]	[ ]	_____
D.	HEART DISEASE	[ ]	[ ]	_____
E.	HIGH BLOOD PRESSURE	[ ]	[ ]	_____
F.	SUICIDE, MENTAL ILLNESS	[ ]	[ ]	_____
G.	STROKE	[ ]	[ ]	_____

IX. HIV HISTORY

A. HIV TEST: DATE AND LAST RESULT:_____

B. LAST CD4_____ DATE DIAGNOSED __/__/__

C. HOW CONTRACTED:_____

X. MEDICATIONS (PRESCRIPTIONS & NON-PRESCRIPTION) INCLUDE NAME, DOSAGE & FREQUENCY:

1.	5.
2.	6.
3.	7.
4.	8.

XI. ALLERGIES (Describe Symptoms): _____

XII. HABITS AND LIFESTYLE

1. WHERE DO YOU EAT MEALS?_____ DO YOU HAVE ACCESS AND RESOURCES TO OBTAIN AN ADEQUATE SUPPLY OF FOOD? [ ] YES [ ]NO IF YES, WHAT RESOURCES:_____
2. WHAT IS YOUR CURRENT LIVING SITUATION (PARENTS, FRIENDS, SQUAT, STREET, FOSTER HOME SCHOOL, ETC.)?_____
3. ANY RECENT LIFE CHANGES (DIVORCED, MOVED, DEATH, ETC.)? _____
4. DO YOU TAKE DRUGS? [ ] YES [ ]NO IF YES, PLEASE LIST: _____
   IF YOU TAKE DRUGS, HOW DO YOU TAKE THEM (SNORT, SHOOT UP, SKIN POP, SMOKE, POP, ETC.)?_____
   DO YOU SHARE NEEDLES?_____
5. DO YOU DRINK ALCOHOL? [ ] YES [ ]NO IF YES, NUMBER OF DRINKS PER DAY:_____ PER WEEK:_____
   IF NO, WHEN DID YOU QUIT? _____
   HAVE YOU EVER HAD A BLACKOUT WHILE DRUNK OR HIGH? (HAVE YOU DONE THINGS THAT YOU DON'T REMEMBER DOING)? [ ] YES [ ] NO
   DO YOU SMOKE/CHEW TOBACCO? [ ] YES [ ]NO IF YES, HOW LONG _____HOW MANY CIGARETTES A DAY:____ # OF YRS.____
   HAVE YOU EVER SMOKED? [ ] YES [ ]NO IF YES, HOW LONG_____. WHEN DID YOU QUIT?_____
6. SEXUALLY TRANSMITTED DISEASES? [ ] YES[ ]NO WHAT DIAGNOSIS:_____
   HOW, WHEN, WHERE TREATED: _____
   CLIENT'S SEXUAL ORIENTATION:_____
   HOW MANY PARTNERS HAS CLIENT HAD IN PAST YEAR?_____ DOES CLIENT USE CONDOMS? [ ] YES [ ]NO
7. HAS ANYONE EVER TOUCHED YOU IN A WAY THAT WAS FRIGHTENING, PAINFUL, OR MADE YOU FEEL UNCOMFORTABLE? [ ]YES [ ] NO
   WHAT HAPPENS WHEN YOU ARGUE WITH YOUR PARTNER?_____
8. IS THERE SOMETHING YOU NEED SUPPORT WITH OR A REFERRAL FOR? [ ] YES [ ]NO IF YES, SPECIFY:_____

XIII. REVIEW OF SYSTEMS (CHECK, IF POSITIVE)

☐DIZZINESS_____	☐ABDOMINAL PAIN_____	☐BLOOD IN URINE_____
☐HEADACHES PAIN_____	☐DIARRHEA/CONSTIPATION_____	☐DIFFICULT ERECTION_____
☐NUMBNESS/WEAKNESS_____	☐BLACK STOOLS_____	☐DISCHARGE FROM VAGINA/PENIS_____
☐VISUAL PROBLEMS _____	☐RECTAL BLEEDING_____	_____
☐HOARSENESS/COUGH_____	☐WEIGHT LOSS_____	☐RASH,SORE,ITCHING_____
☐SHORTNESS OF BREATH_____	☐PAINFUL/DIFFICULTY URINATION_____	☐PAINFUL JOINTS_____
☐CHEST PAINS_____	☐EXCESSIVE URINE_____	☐SWOLLEN ANKLES_____
☐PALPITATIONS_____	☐EXCESSIVE THIRST_____	

_____ INTERVIEWER SIGNATURE

_____ INTERVIEWER NAME

_____ DATE

NAME:_____ HCH #:_____ DATE:_____

TEMP_____ PULSE _____ R_____ BP_____

WEIGHT_____ HEIGHT_____ CONTACT_____

GENERAL APPEARANCE:

HEAD: _____

EYES/FUNDI: _____

EARS/NOSE: _____

ADENOPATHY: _____

OROPHARNYX: _____

NECK: _____

HEART: _____

_____

LUNGS: _____

_____

BREASTS: _____

ABDOMEN: _____

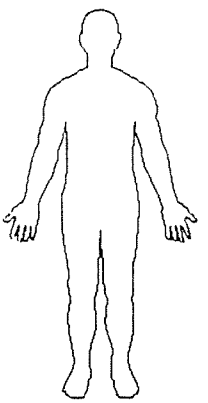
_____

RECTAL/PROSTATE: _____

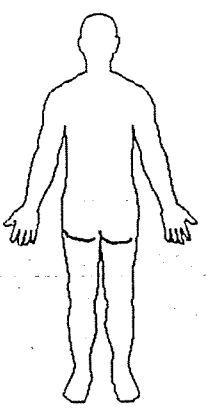
GENITALIA/PELVIC: _____

EXTREMITIES: _____

PULSES: _____



(ANT)



(POST)

NEURO: _____

MMSE: _____

CN: _____

MOTOR: _____

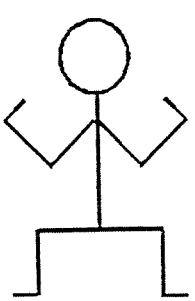
SENSATION: _____

CEREBELLAR: _____

GAIT: _____

SKIN: _____

DTR'S:



ASSESS/PLAN:

ORDERS:

CBC	☐	X Ray.....			
SMA 7/20	☐	CT Scan.....			
LFT	☐	Sonogram.....			
Amylase	☐	MRI.....			
HIV	☐	EKG	☐		
RPR	☐	Echo	☐		
CD4	☐	PFT	☐		
Viral Load	☐	PEFR	☐		
TSH	☐	Others.....			
Hepatitis profile	☐	.....			
HepC	☐	.....			
UA	☐	.....			
		PPD	☐		

REFERRALS:

Case Management/SW	☐
Mental Health	☐
Addictions Counselor	☐
Vision Van	☐
Diabetes Class	☐

Groups.....

Provide Education on .....

.....

Outside Referral to:

.....

.....

.....

RTC.....

Medications/Injections.....

.....

PROVIDER SIGNATURE DATE PRINT NAME

CAM 6a

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 1 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐ Infant Metabolic Screen:

Diet (24 hours): Breast Milk Formula WIC yes ☐ no ☐
Stools Urine: Sleep: Sleep arrangements:

Growth & Development
_____Raises head slightly _____Responds to sound
_____Has tight grasp _____Fixes on face
_____Follows objects to midline _____May smile

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Vitamins, flouride 0.25 mg q.d.
_____ Delay solids
_____ Feeding/ Spitting up

Health
_____ Hiccups/ Sneezing/ URI
_____ Irregular respirations
_____ Rashes

Safety
_____ Fire retardant clothing
_____ Car seats
_____ Smoke detector
_____ Crib safety/ falls

Psychosocial
_____ Pacifier/ crying/ colic
_____ Hold, cuddle
_____ Talk to baby
_____ Vision/ colors
_____ Attention to other children

Assessment/Plan:

Provider: _____

CAM 66

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 2 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐ Infant Metabolic Screen:

Diet (24 hours): Breast Milk Formula WIC yes ☐ no ☐
Stools Urine: Sleep: Sleep Arrangements:

Growth & Development
_____Holds head in middle
_____Lifts head and chest
_____Follows objects 180°
_____Coos, laughs, locates sound
_____Social smile

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17: Other:		

Anticipatory Guidance

Nutrition
_____ Vitamins, flouride 0.25 mg q.d.
_____ Delay solids
_____ Bottles in bed

Health
_____ Infant tylenol gtt
_____ Hiccups/ Sneezing/URI
_____ Irregular respirations
_____ Rashes

Safety
_____ Rolling/falling
_____ Toys
_____ Car seat
_____ Burns/Hot liquids
_____ Crib safety

Psychosocial
_____ Pacifier/crying/ colic/spoiling
_____ Hold/cuddle/play
_____ Talk to baby
_____ Vision/colors
_____ Attention to other children

Assessment/Plan:

Provider: _____

CAM 6c

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 4 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐ Infant Metabolic Screen:

Diet (24 hours): Breast Milk Formula

Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Smiles spontaneously
_____Begins reaching
_____Hands together
_____Moves arms to grasp
_____Head steady
_____Rolls front and back
_____Laughs out loud

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		

Anticipatory Guidance

Nutrition
_____Flouride suppl.
_____? cereals with spoon delay other solids

Health
_____Teething
_____Respiratory infections
_____Vomiting/ Diarrhea
_____Thumbsucking

Safety
_____Aspirations
_____Toys
_____Car seat
_____Discourage walker
_____Falls/Burns

Psychosocial
_____Spoiling
_____Interaction with other siblings
_____Talking to baby

Assessment/Plan:

Provider: _____

CAM 6d

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 6 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours): Breast Milk Formula

Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Reaches & transfers
_____Rolls back to front
_____Sits with support
_____Turns to sound
_____Reacts to strangers
_____Lifts cup, holds bottle
_____Weight bearing
_____No head lag
_____Babbles/Laughs

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____Cereals, fruits, veg.
_____Use of spoon and cup

Health
_____Teething
_____No bottles in bed
_____Head injury
_____URI
_____Thumbsucking

Safety
_____Protect from hot liquids, dangling cords, tablecloth
_____Water & Bathtub safety
_____Car seat
_____Poisoning/ Ipecac
_____Soft shoes
_____Use gates on stairs

Psychosocial
_____Stimulate speech
_____Separation anxiety

Assessment/Plan:

Screen: Hgb_____

Provider:_____

CAM 6e

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 9 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours): Breast Milk Formula Solids

Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Creeps, Crawls, cruises
_____Pulls to stand
_____Uses pincher grasp
_____Finger feeds
_____Sits well
_____Understands no & bye bye
_____Retrieves hidden toy
_____Starts to explore
_____"Dada/Mama" nonspecifically

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
Health
Safety

_____Pica
_____Dental care
_____Water safety
_____Babyproofing the house
_____Poison/ burns
_____Aspiration
_____Toddler car seat if wt. 20 lbs.

Psychosocial

_____Use of "no"
_____Discipline consistency
_____Masturbation
_____Breath holding spells
_____Social games
_____Night wakening
_____Favorite toy or possession
_____stairs
_____Stimulate speech

Assessment/Plan:

Provider: _____

CAM 6f

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 12 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours): Breast Milk Formula Solids

Stools Urine: Sleep: Sleep arrangements:

Growth & Development

_____Walks with support/alone

_____Throws object

_____Uses mature pincher grasp

_____Makes 1-3 words or meaningful sound

_____Gives hug

_____Dada/Mama specifically

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
Other:		

Anticipatory Guidance

Nutrition
- _____ Table foods
- _____ Drop in appetite
- _____ Off bottle
- _____ Regular milk

Health
- _____ Tylenol
- _____ Respiratory infections

Safety
- _____ Hot liquids
- _____ Use of "no"
- _____ Kitchen, stair, water & car safety
- _____ Fences, gates, latches
- _____ Poisoning, Ipecac

Psychosocial
- _____ Bedtime stories/ books
- _____ Delay toilet training
- _____ Discipline
- _____ Favorite toy possession
- _____ Stimulate speech

Assessment/Plan:

Screen: Hgb_____

Lead_____

Sickle cell_____

Provider:_____

CAM 6g

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 15 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):
_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Hrs. of sleep per night
_____Naps per day

Growth & Development
_____Builds tower of 2 blocks
_____Uses 3 to 6 words
_____Understands simple commands
_____Creeps upstairs

_____Walks well
_____Feeds self with fingers
_____Points to 1 or 2 body parts

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____Utensil use
_____Diet, snacks
_____Wean off bottle
_____Drop of appetite

Health
_____Dental care
_____Respiratory infections

Safety
_____Hot liquids
_____Kitchen, stair, water & car safety
_____Fences, gates, latches
_____Poisoning, Ipecac

Psychosocial
_____Bedtime stories/ books
_____Delay toilet training
_____Discipline
_____Favorite toy or possession
_____Stimulate speech
_____Temper tantrums

Assessment/Plan:

Provider: _____

CAM 6 h

CAMILLUS HEALTH CONCERN

HEALTH MAINTENANCE ASSESSMENT - 18 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours):	_____Bread, cereal, rice, pasta	_____Stools per day
	_____Fruits, vegetables	_____Voids per day
	_____Milk, yogurt, cheese	_____Toilet training
	_____Meat, poultry, fish, beans	_____Naps per day
		_____Hrs. of sleep per night
Growth & Development	_____Uses spoon, feeds self	_____4-10 words
	_____Removes garment	_____Pulls toy
	_____Imitates housework	_____Stacks 3 to 4 blocks
	_____Dumps from container	_____Walks up stairs
		_____Kicks/Throws

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition	_____ Pica/Lead
	_____ Diet, snacks
	_____ Wean off bottle
	_____ Drop of appetite
Health	_____ Dental care
	_____ Respiratory infections
Safety	_____ Hot liquids
	_____ Kitchen, stair, water & car safety
	_____ Fences, gates, latches
	_____ Poisoning, Ipecac
Psychosocial	_____ Bedtime stories/ books
	_____ Night fears
	_____ Temper tantrums
	_____ Discipline
	_____ Favorite toy or possession
	_____ Stimulate speech

Assessment/Plan:

Provider: _____

CAM 6:

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 24 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):
_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development
_____Runs well
_____Helps to undress
_____Imitates adults
_____Dumps from container
_____Open doors/climbs

_____20 words
_____Handles spoon well
_____Stacks 5 to 6 blocks
_____Walks up & down stairs
_____Kicks ball/Throws

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____Pica/Lead
_____Diet, snacks
_____Avoid control struggles/eating

Health
_____Dental care
_____Day napping varies

Safety
_____Crib to bed
_____Car seat
_____Matches/ Burns/ Falls/ Water safety
_____Fences, gates, latches
_____Play equipment

Psychosocial
_____Bedtime stories/ books
_____Night fears
_____Temper tantrums
_____Discipline
_____Unable to share
_____Toilet training/ Bedwetting
_____Genital explor.

Assessment/Plan:

Screens: CBC_____
Lead_____

Provider:_____

CAM 6j

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 30 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ❑ defer ❑

Diet (24 hours):

_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development

_____Puts on clothing
_____Washes & dries hands
_____Separates from Mom easily
_____Plays tag
_____Copies O

_____Uses plurals
_____Gives 1st & last name
_____Stacks 8 blocks
_____Jumps in place
_____Balance on 1 foot/1sec.

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Diet
_____ Healthy snacks
_____ Avoid control struggles/eating

Health
_____ Dental care
_____ Day napping varies

Safety
_____ Crib to bed
_____ Car seat
_____ Matches/ Burns/ Falls/ Water safety
_____ Fences, gates, latches
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Temper tantrums
_____ Discipline
_____ Unable to share
_____ Toilet training/ Bedwetting
_____ Genital explor.

Assessment/Plan:

Provider: _____

CAM 6k

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 3 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):
_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development
_____Buttons up
_____Dresses with supervision
_____Separates from Mom easily
_____Plays tag
_____Copies O

_____Uses plurals/past tenses
_____Gives 1st & last name
_____Stacks 8 blocks
_____Broad jumps
_____Group play

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Diet
_____ Healthy snacks
_____ Avoid control struggles/eating

Health
_____ Dental care
_____ Day napping varies

Safety
_____ Street safety
_____ Car seat
_____ Matches/ Burns/ Falls/ Water safety
_____ Fences, gates, latches
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Temper tantrums
_____ Discipline
_____ Pretend play
_____ Group play/sharing
_____ Toilet training/ Bedwetting
_____ Genital explor.

Assessment/Plan:

Screen: Dental referral_____

Provider:_____

CAM 61

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 4 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):
_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Toilet training
_____Naps per day
_____Hrs. of sleep per night

Growth & Development
_____Buttons up
_____Dresses self
_____Copies +
_____Copies ☐
_____Balances 5 seconds

_____Draws 3 part man
_____Names 3 to 4 colors
_____Counts to 5
_____Hops on 1 foot
_____Catches bounced ball

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
4. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Small portions
_____ Healthy snacks
_____ Avoid control struggles/eating

Health
_____ Dental care
_____ Day napping varies

Safety
_____ Street safety
_____ Fire safety
_____ Matches/ Burns/ Falls/ Water safety
_____ Toxic substances
_____ Bicycle safety
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Discipline
_____ Pretend play
_____ Group play/sharing
_____ Toilet training/ Bedwetting
_____ Sexual curiosity

Assessment/Plan:

Screen: Dental referral_____
CBC_____
Lead_____
UA_____
Vision_____
Audiometry_____

Provider:_____

CAM 6m

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 5 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):
_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Hrs. of sleep per night

Growth & Development
_____Skips, walks on tiptoe
_____Dresses self
_____Ties shoes
_____10 word sentences
_____Balances 10 seconds

_____Draws 6 part man
_____Prints first name
_____Copies ▲
_____Backward heal/toe walk
_____Catches bounced ball

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Small portions
_____ Healthy snacks

Health
_____ Dental care

Safety
_____ Street safety
_____ Fire safety
_____ Matches/ Burns/ Falls/ Water safety
_____ Toxic substances
_____ Bicycle safety
_____ Medication safety
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Discipline
_____ Dressing up play
_____ Gender Identification
_____ Understands right and wrong

Assessment/Plan:

Screen: Dental referral_____

Provider:_____

CAM 6 n

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 6 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
Last Name: _____ First Name: _____ Gender: _____
Medications: _____ Allergies: _____
Social Hx: _____
Immunizations: current ☐ defer ☐

Diet (24 hours):
_____Bread, cereal, rice, pasta
_____Fruits, vegetables
_____Milk, yogurt, cheese
_____Meat, poultry, fish, beans

_____Stools per day
_____Voids per day
_____Hrs. of sleep per night

Growth & Development
_____Bounces ball 6 times
_____Ties shoelaces
_____Counts to 10
_____Prints name and numbers
_____Grade in school

_____Draws 6 part man with clothes
_____Knows right from left
_____Backward heal/toe walk

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
_____ Avoid junk food
_____ Healthy snacks
_____ Maintain appropriate wt.

Health
_____ Dental care
_____ Regular exercise

Safety
_____ Street safety
_____ Fire safety
_____ Matches/ Burns/ Falls/ Water safety
_____ Learn to swim
_____ Bicycle safety
_____ Limit TV viewing
_____ Gun safety

Psychosocial
_____ Bedtime stories/ books
_____ Discipline
_____ Relationship with peers
_____ Communication with Parents/Praise
_____ Rules/Chores

Assessment/Plan:

Screen: Dental referral_____
Cholesterol/Trig
if + family hx_____

Provider:_____

CAM 60

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 7-12 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta

_____Fruits, vegetables

_____Milk, yogurt, cheese

_____Meat, poultry, fish, beans

Development:

Grade in school _____ Performance in school _____

Career plan _____ Problems with peers/siblings _____

Favorite Activity

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
a. Tanner stage:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
- _____ Avoid junk food
- _____ Healthy snacks
- _____ Maintain appropriate wt.

Health
- _____ Dental care
- _____ Regular exercise

Safety
- _____ Street safety
- _____ Fire safety
- _____ Matches/ Burns/ Falls/ Water safety
- _____ Learn to swim
- _____ Bicycle safety
- _____ Limit TV viewing
- _____ Gun safety

Psychosocial
- _____ Books/Library card
- _____ Communication with parents
- _____ Alcohol/Drugs/ Smoking
- _____ Sexual development
- _____ Pubertal teaching

Assessment/Plan:

Screen: Dental referral _____
Cholesterol/Trig _____
if + family hx _____
CBC & UA _____
Vision _____
Audiometry _____
PPD _____

Provider: _____

CAM 6p

HEALTH M[illegible]ENANCE ASSESSMENT - ADOL[illegible]NT VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____

Last Name: _____ First Name: _____ Gender: _____

Medications: _____ Allergies: _____

Social Hx: _____

Immunizations: current ☐ defer ☐

Diet (24 hours):

_____Bread, cereal, rice, pasta

_____Fruits, vegetables

_____Milk, yogurt, cheese

_____Meat, poultry, fish, beans

Development:

Grade in school _____ Performance in school _____

Career plan _____ Problems with peers/siblings _____

Favorite Activity _____

Drugs _____ Sexual activity _____

Menstrual Hx

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
a. Tanner stage:		
b. Pelvic/pap:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition
- ____ Avoid junk food
- ____ Healthy snacks
- ____ Maintain appropriate wt.

Health
- ____ Dental care
- ____ Regular exercise
- ____ Breast / Testes self exam
- ____ Contraceptive counseling

Safety
- ____ Alcohol/Drugs/ smoking
- ____ STDs/AIDS
- ____ Gun safety

Psychosocial
- ____ Plans for future
- ____ Communication with parents

Assessment/Plan:

Screen: Dental referral _____
Cholesterol/Trig _____
if + family hx _____
CBC & UA _____
Vision _____
Audiometry _____
PPD _____

Provider: _____

CAM 18

Camillus Health Concern, Inc.
Immunization Record

Last Name _____ First Name _____ Client # _____

Vaccine	Date given mm/dd/yy
DTP/DTaP[1]	
DTP/DTaP[2]	
DTP/DTaP[3]	
DTP/DTaP[4]	
DTP/DTaP[5]	
DTP/Hib [1]	
DTP/Hib [2]	
DTP/Hib [3]	
DTP/Hib [4]	
Td [1]	
Td [2]	
Td [3]	
OPV/IPV [1]	
OPV/IPV [2]	
OPV/IPV [3]	
OPV/IPV [4]	
Measles	
MMR 1	
MMR 2	
Hib 1	
Hib 2	
Hib 3	
Hib 4	
Hep B 1	
Hep B 2	
Hep B 3	
Varivax [1]	
Varivax [2]	
Td Booster	
Td Booster	

EXAM	DATE	RESULTS and COMMENTS
PPD		
PPD		
PPD		
PPD		
PPD		
PPD		
PPD		
PPD		
CXR		
Lead Level		
Sickle Cell Screen		

HEALTH CARE FOR THE HOMELESS

MAMMOGRAM QUESTIONNAIRE

1. Do you have a history of Breast Cancer? ☐ No ☐ Yes

2. Does anyone in your family have a history of breast cancer? ☐ No ☐ Yes

3. Do you have breast implants? ☐ No ☐ Yes

4. Do you have lumps or nodules in or around breast area/under arms? ☐ No ☐ Yes If yes, where? _____

5. Do you have any nipple discharge? ☐ No ☐ Yes If yes, which nipple? ☐ Left ☐ Right

6. Do you have inverted nipples? [Are nipples turn inward] ☐ No ☐ Yes

7. Are you wheelchair? ☐ No ☐ Yes Any difficulty standing? ☐ No ☐ Yes

8. Have you had a previous mammogram(s)? ☐ No ☐ Yes If yes, where?

   Are you able to gate a copy of the films? ☐ No ☐ Yes

_____ _____

Client Signature Date

CLIENT LAST NAME:		FIRST NAME:		HCH#:	

Housing Opportunities Management and Essential Services, Inc.
408 East State Street • Ithaca, New York 14850 (607) 272-1741

COMMUNITY LIVING SERVICES
MEDICAL EXAMINATION FORM

THIS RECORD IS CONFIDENTIAL EXAM DATE: _____

SECTION I. (To be filled out by resident or staff)

_____ _____ _____ _____ _____
(Last Name) (First Name) (Middle Name) (Date of Birth) (Sex)

_____ _____ _____ _____
(Home Address) (City or Town) (State) (Zip Code)

Pertinent Medical History/Information: _____

_____

_____

Allergies: _____

_____

Current Medications:

MEDICATION	DOSAGE	TIMES PER DAY	PRESCRIBED BY WHOM	REASON

Diet: Regular _____ Special (explain): _____

_____

SECTION II. PHYSICAL EXAMINATION

(To be filled out by a physician or physician's assistant. Items checked ( ) were examined and found normal. Deviations from normal are noted. If items require additional description, please record on extra sheet.)

Height: _____ feet _____ inches. Weight: _____ B/P _____

Respiratory _____ Pulse _____ Temperature _____

Eyes: Right _____ Left _____

Ears Hearing: Right _____ Left _____

HOM 10-2

	NORMAL	IF ABNORMAL PLEASE EXPLAIN:
Nose	[ ] YES [ ] NO	_____
Mouth	[ ] YES [ ] NO	_____
Throat	[ ] YES [ ] NO	_____
Neck	[ ] YES [ ] NO	_____
Breasts	[ ] YES [ ] NO	_____
Lungs	[ ] YES [ ] NO	_____
Heart	[ ] YES [ ] NO	_____
Abdomen	[ ] YES [ ] NO	_____
Hernia	[ ] YES [ ] NO	_____
Ano-Rectal	[ ] YES [ ] NO	_____
Genitourinary and Gynecological	[ ] YES [ ] NO	_____
Lymphatic System	[ ] YES [ ] NO	_____
Nervous System	[ ] YES [ ] NO	_____
Skin	[ ] YES [ ] NO	_____
Feet	[ ] YES [ ] NO	_____
Varicose Veins	[ ] YES [ ] NO	_____
Orthopedic Impairments	[ ] YES [ ] NO	_____

SECTION III. DIAGNOSTIC TESTS

(UNLESS OTHERWISE SPECIFIED ARE DONE AT THE PHYSICIAN'S DISCRETION. RESULTS CAN BE SENT AT A LATER DATE.)

CBC Date: _____ Results: _____
Chest X-Rays Date: _____ Results: _____
Electrocardiogram Date: _____ Results: _____
Stool for Occult Blood Date: _____ Results: _____
Pap Smear Date: _____ Results: _____
Urinalysis: Date: _____ Specific gravity _____ Reaction _____
Albumen _____ Sugar _____

Optional: Blood serologic test for syphilis

Date: _____ Name of test: _____ Results _____
Other: _____

Diagnostic Findings: (Indicate major and minor) _____

SECTION IV. IMMUNIZATIONS & SCREENINGS

(IMMUNIZATIONS ARE TO BE BROUGHT UP TO DATE IF DUE)

Tetanus Date: _____ Results: _____
Influenza Vaccine Date: _____ Results: _____
Hep B Screening Date: _____ Results: _____
TB Screening (Every 2 years) Date: _____ Results: _____
Other Date: _____ Results: _____

SECTION V. PHYSICAL CAPABILITIES:

Under "Physical Activities" and "Working Conditions" use symbols as follows:
(√) No limitation (X) Limitation (O) To be avoided

Physical Activities: Walking ___ Standing ___ Stooping ___ Kneeling ___ Lifting ___
Reaching ___ Pushing ___ Pulling ___ Climbing Stairs ___
Other (specify) _____

Working Conditions: Outside ___ Inside ___ Humid ___ Dry ___ Dusty ___
Sudden temperature changes ___ Other (specify) _____

SECTION VI. RECOMMENDATIONS:

[ ] Is examination by specialist advisable for completeness of diagnosis or prognosis?
If so, specify which specialty.
_____

[ ] Refraction [ ] X-ray of chest [ ] Other diagnostic procedures (Specify) _____

[ ] Hospitalization (Specify reasons and approximate duration) _____

[ ] Treatment (Specify type and approximate duration) _____

[ ] Additional _____

SECTION VII. DOCTOR'S DIAGNOSTIC FINDINGS:

(over)

1 of 10-4

SECTION VIII. ALCOHOL RECOMMENDATIONS RESIDENT NAME: _____

Is alcohol contradicted with medications this person is on?

[ ] YES [Limited] (Please give guidelines, e.g.: glass of wine on special occasions, 2-3 beers twice a week, etc.)

[ ] NO _____

_____

SECTION IX. PHYSICIANS GUIDELINES FOR OVER-THE-COUNTER MEDICATIONS

OVER-THE-COUNTER MEDICATIONS (INCLUDING VITAMINS) WILL NOT BE USED BY A PERSON FOR MORE THAN TWO DAYS WITHOUT CONSULTING A PHYSICIAN.

We do keep some over-the-counter medications on hand for use when the physician cannot be consulted immediately.

Are any of the following preparations contraindicated for this person given their present medical condition and the medications they are currently taking?

CONDITION:	PREPARATION: (to be used according to label directions)	ALTERNATIVE SUGGESTIONS OR COMMENTS:	APPROVAL YES	NO
Pain or Fever	Aspirin			
	Tylenol			
Indigestion	Pepto Bismol Liquid			
Diarrhea	Kaopectate Liquid			
Diarrhea/Indigestion	Mylanta Liquid			
Constipation	Senokot			
Cough	Robitussin DM			
Cold Symptoms	decongestant			
	antihistamine			
Other:				

Can this person take a multivitamin supplement daily? Yes _____ No _____
Suggestions for type (e.g., with iron, or minerals, or other specific recommendation):

_____ _____

Physician's Signature Date

HPH 5

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

NON PRODUCTIVE COUGH

S_____

_____

_____

O:_____

_____

_____

A1 Non Productive Cough:_____

_____

A2 PROVIDED MEDICATION(s):_____

Assessed for pregnancy; drug allergies; contraindicators

Discussed relief measures: remove bronchial irritants (smoking, second hand smoke); drink at least 2 quarts of fluids per day; adequate rest; vitamin supplements

Advised to follow-up by contacting HPHP (or County GMC or hospital ER during off hours) medical provider if cough becomes productive of yellow, green, brown or bloody sputum, if breathing becomes difficult or should symptoms persist or worsen

_____

_____

P Patient to contact HPHP as necessary for follow-up

_____

SIGNED_____ Page #_____

HSA-756L

HCH, Inc. / CONNECT Project

NURSING ASSESSMENT FORM

BAL 15

Date: _____

Address Client Assessed: _____ Balto., MD 212 Phone: _____
Street Address / Apt. No. Zip

DOB: _____ SSN: _____ ER Contact: _____

Referring Agency; _____ Contact: _____

Reason for Referral: _____

Primary Care Provider: _____ PCP's Phone; _____

Past Medical History: _____

HIV History: CD4 _____ (Date) VL _____ (Date) OIs: _____

Current HAART Meds: _____

Any Current Problems/Side Effects on HAART? No____ Yes_____ If yes, describe: _____

Past HAART Meds: _____

Reason for stopping HAART Meds: _____

Past Hospitalizations (Starting with most recent): _____

Teaching Needs: _____

Treatment Plan: _____

CLIENT LAST NAME: FIRST: HCH#:

PHYSICAN EXAMINATION

ROS:
NEURO:
CV:
Resp.:
GI:
GU:
EENT:
Skin:

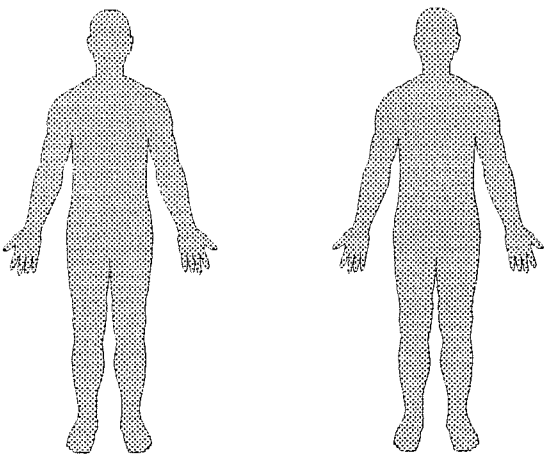
NOTES:

Skin: ☐ Intact ☐ Red ☐ Compromised

(described below)

Indicate Location and Shape of Skin Abnormalities of Figure Below:

Front ***Back***



Extremites: ☐ Moves All Well

☐ Strength Equal

☐ Wounds/Deformity

Describe:_____

☐ Pulse:

☐ Color:

☐ Capillary Refill: ☐ > 2 seconds

☐ < 2 seconds

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

R/O OTITIS R/L EAR:

S:_____

_____

_____

O:_____

_____

_____

_____

A1 PROBABLE OTITIS OF_____EAR:_____

_____

_____

A2 ENROLLED IN HPHP THROUGH:_____

Instructed follow up at:_____ on date:_____

Instructed re: measures to prevent future ear infections; keep ear clean and dry

Children: advised parent to avoid propping bottle; never insert objects (Q-tips/fingers) into ear canal

Relief measures reviewed: rest, fluids, symptomatic medications (Tylenol, etc.)

For repeated ear infections: assess for diabetes and immunosuppression and referred to ENT Specialist

_____

_____

P: Client to follow-up as instructed. Client to initiate contact with HPHP as necessary for follow-up

Children: parents to F/U immediately if symptoms worsen or persist

_____

SIGNED_____ Page #_____

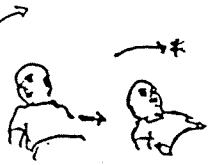
MON 14

PRIMARY CARE FACILITY **NAME:**
CHART #:
D.O.B.:

Developmental Milestones
(Items marked "O" are by observation)

By 2 weeks
___ Regards face
___ Lifts head from prone (O)
___ Responds to sounds

By 2 months
___ Vocalizes
___ Smiles responsively
___ Follows to midline (O)



By 4 months
___ Holds head up to 90 angle (O)
___ Listens then vocalizes (can you have a "conversation" with your baby?)
___ Regards own hands
___ Follows past midline (O)
___ Grasps rattle
___ No persistent fist clenching

By 6 months
___ Imitates speech sounds heard in preceding minute
___ Turns to voice
___ Rolls over
___ Reaches for objects with each hand
___ Doesn't resist cuddling
___ No persistent fist clenching
___ No avoidance of eye contact*

By 9 months
___ Sits alone (O)
___ Stands holding to solid object (not human)
___ Thumb-finger grasp
___ Says "Mama/Dada" nonspecific
___ Says "babababa" or "lalalala," etc.

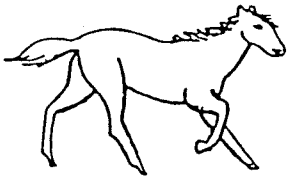
By 12 months
___ Stands alone 2 seconds
___ Bangs 2 blocks held in hands
___ Says "Dada/Mama" specifically
___ Responds to "NO"
___ Plays Pat-a-cake or waves "bye-bye"
___ Doesn't use one hand in preference to the other
___ No avoidance of eye contact*

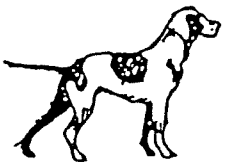
By 15 months
___ Walks well
___ Says 1 word besides "Mama/Dada"
___ Points to desired objects
___ No concern that child can't hear or "tunes out"*
___ No avoidance of eye contact*

By 18 months
___ Imitates household chores like sweeping, dusting
___ Says 4 words besides "Mama/Dada"
___ Points to 1 body part ("show me your nose, eyes, etc.)
___ Drinks from a cup
___ Scribbles
___ No avoidance of eye contact*

By 21 months
___ Walks up stairs holding railing
___ Says 6 words besides "Mama/Dada"
___ Indicates at least 2 wants with single words ("Milk!", "More!", "Cookie!")
___ Feeds self with spoon
___ No toe walking*

* These behaviors, if persistent, are abnormal at any age

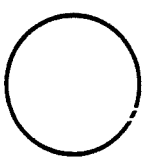
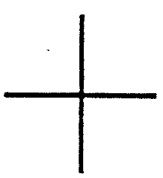






By 2 years
___ Kicks ball forward
___ Combines 2 words
___ Strangers understand at least half of child's speech
___ Points to 6/8 named body parts (nose, eyes, ears, mouth, hands, feet, tummy, hair) (O)
___ Names 1/5 animal pictures (O)
___ Follows 2 step command (no gesture)
___ Takes off clothing (other than hat)
___ No rocking, handflapping or headbanging*

By 2 1/2 yrs
___ Points to 4/5 animal pictures (e.g."show me the dog", child points) (O)
___ Repeats two digits (Say "2", now say "4-7", "5-8", "3-9") Pass 1 (O)
___ Puts on clothing
___ Jumps in place

By 3 yrs
___ Can hold a conversation (2-3 sentences)
___ Names 4/5 pictures of animals (O)
___ Knows 2/5 actions of animals (O) (which one flies, meows, barks)
___ Understands what to do when tired, cold, hungry (1/3) (O)
___ Imitates vertical line (O)
___ Washes and dries hands
___ No echolalia (repeating what was just said)

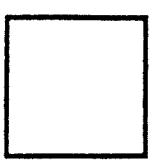
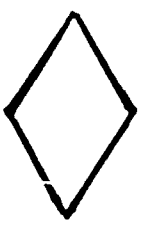



By 4 years
___ Knows first & last name
___ Understands what to do when tired, cold, hungry (2/3) (O)
___ Copies a circle (O)
___ Plays interactive games (e.g.tag)
___ Walks up stairs not holding on
___ Can report what ate that day (O)
___ Toilet trained

By 5 years
___ Hops 2 or more times
___ Names 4 colors (O)
___ Defines 5/8: "What is a ball, lake desk, house, banana, curtain, fence, ceiling?" (O)
___ Dresses without supervision
___ Copies a cross (O)

By 6 years
___ Copies a square (O)
___ Adds numbers 1-5 (O)
___ Draws a person with 6 parts (O)
___ Satisfactory school performance and behavior

By 7 years
___ Copies a diamond (O)
___ Ties shoelaces (O)
___ Knows days of week (O)
___ Knows home address (O)
___ Appropriate age/grade

By 8-13 years
___ Appropriate age/grade
___ Good peer relationships
___ No behavioral problems

Comments:_____
_____

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

RULE OUT VIRAL 'FLU' SYNDROME

S_____

_____

_____

_____

O CLIENT SEEN AT:_____

_____

_____

_____

A1 PROBABLE VIRAL 'FLU' SYNDROME:_____

_____

A2 PROVIDED MEDICATION(s):_____

Assessed for: pregnancy; drug allergies; contraindications

Discussed measures for relief of symptoms: rest, increase fluid intake to 2 quarts per day, avoid exposure to cigarettes, avoid alcohol, use herbs/teas

Advised to: avoid cough suppresants, except to aid in sleeping and to follow-up by contacting HPHP (or County GMC or hospital ER during off hours) should symptoms worsen or persist

Enrolled in HPHP

Bus pass provided

_____

_____

P Client to initiate contact with HPHP as necessary

_____

SIGNED_____ Page #_____

HSA-756C

MER 7

PEDIATRIC SCREEN

Date:_____ MA#_____

Name:_____ S.S._____ D.O.B._____

Mother/Father Name:_____

MEDICAL PROBLEMS/HOSPITALIZATIONS:
Chicken Pox

MEDICATIONS:

PERINATAL HISTORY:
Maternal Drug Use

Delivery_____ Wt._____

ALLERGIES:

Ht._____

IMMUNIZATIONS: (current/delayed)
Lead Test

Wt._____

HEAD CIRCUM:_____

NUTRITION: (Formula, BF, Vitamins, WIC, Bottle/Cup)

DEVELOPMENTAL GROWTH:

Milestones (sit 6mo.)(walk 1yr.)

Hearing/Vision/Glasses

Speech

Toliet Training/Diaper Rash/Circumcision

Sleeping Patterns

Behavior/Social/Aggressive/Withdrawn

School/Grade/Special Needs

ACCIDENTS/INJURIES:

DENTAL (fluoride, brush teeth, dental exam):

HEALTH CARE PROVIDER:

APPOINTMENTS:

OTHER SERVICES: (DSS, VNA, E.I., Counseling)

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

POISON OAK

S:_____

_____

_____

_____

O:_____

_____

_____

_____

A1 POISON OAK:_____

_____

A2 PROVIDED MEDICATION(s):_____

Instructed re: proper use; assessed for other skin disorders, sensitive skin or other contraindications

Assess for allergies

Advised of relief measures: proper use of medication; keep skin clean and dry; expose to sunlight when possible

Instructed re: mode of transmission and advised to wear long shirts/pants when in areas where re-exposure may occur

_____

_____

P Client to initiate contact with HPHP as necessary for follow-up

_____

SIGNED_____ Page #_____

HSA-756D

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

NON PRODUCTIVE COUGH

S_____

_____

_____

O:_____

_____

_____

A1 Non Productive Cough:_____

_____

A2 PROVIDED MEDICATION(s):_____

Assessed for pregnancy; drug allergies; contraindicators

Discussed relief measures: remove bronchial irritants (smoking, second hand smoke); drink at least 2 quarts of fluids per day; adequate rest; vitamin supplements

Advised to follow-up by contacting HPHP (or County GMC or hospital ER during off hours) medical provider if cough becomes productive of yellow, green, brown or bloody sputum, if breathing becomes difficult or should symptoms persist or worsen

_____

_____

P Patient to contact HPHP as necessary for follow-up

_____

SIGNED_____ Page #_____

HSA-756L

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

R/O OTITIS R/L EAR:

S:_____

_____

_____

O:_____

_____

_____

_____

A1 PROBABLE OTITIS OF_____EAR:_____

_____

_____

A2 ENROLLED IN HPHP THROUGH:_____

Instructed follow up at:_____ on date:_____

Instructed re: measures to prevent future ear infections; keep ear clean and dry

Children: advised parent to avoid propping bottle; never insert objects (Q-tips/fingers) into ear canal

Relief measures reviewed: rest, fluids, symptomatic medications (Tylenol, etc.)

For repeated ear infections: assess for diabetes and immunosuppression and referred to ENT Specialist

_____

_____

P: Client to follow-up as instructed. Client to initiate contact with HPHP as necessary for follow-up

Children: parents to F/U immediately if symptoms worsen or persist

_____

SIGNED_____ Page #_____

CAM 5

DATE: _____ **CHC WOMEN'S HEALTH CLINIC** CHC# _____

NAME: _____ AGE: _____ DOB: _____ ALLERGIES: _____

FDLMP_____ X _____ Days

MENOPAUSE/AGE _____ ERT: NO ___ RES: _____yrs.

G _____ PARA: F _____ P_____ A_____ L_____ SEXUALLY ACTIVE NO YES

Birth Control: None OCP Diaphragm IUD Condoms Other_____

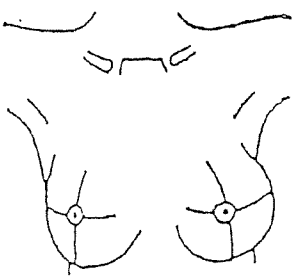
Last PAP: _____ Last MAMMOG _____

F.H. BREAST CA: NO YES: MOTHER SIB AUNT MSBE: NO YES

PMH/STD: MEDS: ETOH: NO / YES
TOB: NO / YES
IVDU: NO / YES
HOMELESS: NO / YES

BS: BP _____ HR_____ R _____ T _____ HT _____ WT _____

BREAST:



PELVIC: EXT.
Vaginal
Cervix

BIMANUAL: CMT: NEG / POS
Adnexa:
Uterus:

KOH
Wet Mount
GM Stain
UCG - +

ASSESSMENT / PLAN: