

Penfield Christian Homes Nursing Assessment

Client Name: _____ DOB: ____/____/____
 Phone #: (____) _____ SSN: ____/____/____
 Emergency Contact: _____ Phone #: (____) _____

Allergies: _____

Current Medications _____

Primary Care Physician: _____ Hospital: _____

Medical History (Check the appropriate box)

Has client or any family member had?:

	Client	Family
1 High Cholesterol.....		
2 Heart Disease.....		
3 Rheumatic Fever.....		
4 High Blood Pressure.....		
5 Asthma.....		
6 Tuberculosis.....		
7 Diabetes.....		
8 Thyroid Problems.....		
9 Liver Disease.....		
10 Stomach Problems.....		
11 Kidney/Bladder Problems.....		
12 HIV/AIDS.....		
13 Hepatitis Type _____.....		
14 Blood Transfusion.....		
15 Allergies.....		
16 Breast Problems.....		
17 Cancer.....		
18 Female/Male or Sexual Problems.....		
19 STD.....		
20 Sexual/Domestic Abuse.....		
21 Mental Illness/ Substance Abuse.....		
22 Other Medical Problems.....		
23 Tobacco use (How much?) _____		
24 No Known Medical Problems.....		

Notes: _____

Most Recent Substances Used	How Much	How Often	How Long	Last Use	Route	Sobriety Dates	Previous Treatment

Please fax results to 1-888-785-0613

Client Name: _____ SSN: _____

Height: _____ Feet _____ inches Weight _____ pounds

Vitals: Temperature: _____ Pulse: _____ Respirations: _____ BP: _____

General Physical	Normal		Abnormal	Comments
Skin				
HEENT				
Neck				
Chest				
Breast				
Heart				
Lungs				
Abdomen				
Musculoskeletal				
Extremities				
Neurological				
Nutritional Assessment				
Not Performed				
Apparently Adequate				
Apparently Inadequate				
Excessive Intake				

PPD: Date Placed _____ Where Placed _____ Date Read _____ Result _____

RPR: Date Drawn _____ Date Results _____ Comments _____

Note: _____

Does client/patient require medically supervised detoxification prior to entering residential treatment? ___No ___Yes

Does client/patient require any further medical or mental health evaluation other than substance abuse treatment?

Yes **No** If yes, please elaborate with recommendations-

Assessment Provider Signature

Date

Assessment Provider Print Name & Title

Phone Number

Please fax results to 1-888-785-0613