OUTPATIENT HEALTH SCREENING

(To be completed by the client.)

Patient Identification

Date:	Time of Arrival to Program:	Emergency Contact: Name_____ Relationship:_____ Number:_____

Drug Allergies: □ None □ _____

Food Allergies: □ None □ _____

Other Allergies: □ None □ _____

Chief Complaint: (Why did you seek care in our program?)_____

_____

_____

_____

_____

_____

_____

_____

Discharge Planning:

Who do you currently live with? _____

Do you anticipate this changing? _____

Educational Data:

Preferred Language: □ English □ Spanish □ Other:_____

□ Can Read □ Can Write □ Other:_____

Do you need a translator? □ No □ Yes : Indicate below:

□ Sign – ASL □ Spanish □ Other:_____

Do you have any Communication Barriers? □ None _____

How do you learn best? □ Written materials □ Demonstration □ Other:_____

Functional Screen: □ Functions/care for self independently □ Needs help from others

□ Limitations identified (What sort of help is needed?) _____

Special Equipment: □ None □ Walker □ Wheelchair □ Cane □ Crutches □ Prosthesis

□ Glasses □ Contact Lenses □ Hearing Aids ___ Left ___ Right

Falls History:

History of Falls? □ No □ Yes Frequency of Falls:_____

Date of last fall:_____

Any injuries from a fall within the last month? □ No □ Yes Describe:_____

Was medical attention received for recent fall? □ No □ Yes Describe: _____

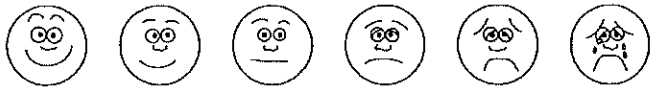
STAFF ONLY: *If any of the above are marked at "YES" response will initiate a Nurse to complete a Morse Fall Assessment.*

Pain Assessment: Do you have pain now? □ No □ Yes

If yes complete the Wong-Baker Pain Scale below.

Wong-Baker FACES Pain Rating Scale (Use if patients are able to accurately communicate pain rating)

On the scale of 0 through 10, indicate the level of pain you are experiencing now. **CURRENT PAIN SCORE:** _____



0 No Hurt **2** Hurts Little Bit **4** Hurts Little More **6** Hurts Even More **8** Hurts Whole Lot **10** Hurts Worst

What makes your pain better? _____ What makes your pain worse? _____

What can we do to help you manage your pain? _____

Any change in behavior related to pain? _____

Character of Pain: □ Sharp □ Dull □ Throbbing □ Stabbing □ Aching □ Burning □ Numb

Frequency: _____ When did pain start? _____

Location (specify area) _____ Duration: □ Constant □ Intermittent

Has impacted: □ Sleep □ Appetite □ Physical Activity □ Relationships □ Emotions □ Concentration □ Other_____

OUTPATIENT HEALTH SCREENING

(To be completed by the client.) Patient Identification

Alcohol/ Drug History: □ Denies □ Social Drinker/ User □ Heavy Drinker/ User

Substance (including tobacco)	Age of 1st use	Last Used	Amount/ Frequency

Withdrawal:

Have you ever experienced withdrawal symptoms? □ No □ Yes If Yes select all that apply

□ Withdrawal Symptoms: □ Confusion □ Blackouts □ Seizures □ Tremors □ DT's □ Diarrhea □ Sweating □ Anxiety

□ Nausea/Vomiting □ Body Aches □ Abdominal Cramps

When was this last experienced? _____

Nutritional Screen:

Have you had unplanned weight loss/gain greater than 10 lbs. in past 3 months or under ideal body weight? □ No □ Yes

Have you had unexplained nausea/vomiting/diarrhea greater than 3 days? □ No □ Yes

Have you experiences a loss of appetite resulting in decreased oral intake? □ No □ Yes

Eating habits/behaviors such as bingeing or inducing vomiting? □ No □ Yes

Are you a newly diagnosed Diabetic? □ No □ Yes

If you are a diabetic, would you consider yourself complaint with medications and diet? □ NA □ No □ Yes

Do you have dental problems that impacts your ability to eat? □ No □ Yes

Do you have problems with chewing/ swallowing? □ No □ Yes

If you have any food allergies, please list them here or check none: □ None _____

STAFF ONLY: If any of the above are marked with "YES," a Nutrition Assessment is indicated. Make referral or notify Dietitian below:

□ *Referral for Nutritional Consultation: (Include on Discharge Care Plan.)*

Location/Name: _____

□ *Nutritional Consultation at the Facility:*

Date request for consult was made: _____ *Time request for consult was made:* _____

Review of Systems: Check any current problems or history of problems listed below:

Respiratory:	□ Cough □ Asthma □ Shortness of Breath □ Emphysema □ COPD □ Other/Describe:
Skin:	□ Cuts, scratches □ Bruises □ Rash □ Other/Describe:
Central Nervous System:	□ Dizziness □ Fainting □ Headache □ Slurred Speech □ Seizure disorder □ Tics □ Other/Describe:
Genitourinary:	□ Pregnant □ Last period: _____ □ Urgency □ Retention □ Urinary incontinence □ Venereal disease □ Other/Describe:
Gastrointestinal:	Last bowel movement: _____ □ Vomiting □ Nausea □ Blood in stool □ Constipation □ Diarrhea □ Hepatitis □ Ulcer □ Other/Describe:
Cardiovascular:	□ Angina □ Hypertension / high blood pressure □ History of heart attack □ Pacemaker □ Edema □ Chest Pain □ Heart Murmur □ Other/Describe:
Musculoskeletal:	□ Cast □ Fracture: describe_____ □ Joint swelling □ Joint stiffness □ Joint Pain □ Muscle spasms □ Back pain □ Amputation (what)_____ □ Other/Describe:_____
Other:	□ Hypothyroid □ Diabetes □ HIV+ □ AIDS □ Hyperthyroid □ Hepatitis □ Other/Describe:

What was the approximate date of your last physical?

Client Signature: **Date:** **Time:**

Practitioner Review of Health Screening: □ **Check if an H&P is needed.**

Practitioner Signature: _____ **Date:**_____ **Time:**_____