# Physical Health Assessment

- ✓ Required for JCAHO certified programs and some DPH services; completed in concert with the comprehensive assessments.
- ✓ Optional for other programs following agency policies.
- ✓ Assess current and past medical issues of the person served that may impact current functioning.
- ✓ To be completed by qualified Medical Professional.

| Data Field | Identifying Information Instruction |
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| **Person's Name** | Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion. |
| **Record Number** | Record your agency's established identification number for the person. |
| **Date of Admission** | Record the date of admission per agency policy. |
| **Organization/Program Name** | Record the organization/program for whom you are delivering the service. |
| **DOB** | Record the person's date of birth. |
| **Gender** | Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes. |
| **Data Field** | **Vital Signs** |
| | Record height, weight, blood pressure, body mass index, respiratory rate, pulse and temperature for person. |
| **Data Field** | **Allergies** |
| | List all known food, medication (include OTC and herbal) and environmental allergies for the person. Note drug sensitivities. If no allergies/drug sensitivities are known, check *No known allergies* and skip to next question. |
| **Data Field** | **Recent Assessments /Examinations** |
| **Most Recent Blood work** | Complete section for all applicable assessments and /or examinations. Additional blood work is required for Opiate Treatment Programs (OTP) |
| **Date** | Record date of test performed |
| **Results** | Record results of test performed |
| **Physician** | List name of physician providing test results |
| **Most Recent Screening** | Complete section for all applicable screenings. Additional screenings are required for Opiate Treatment Programs (OTP) |
| **Date** | Record date of test performed |
| **Results** | Record results of test performed |
| **Physician** | List name of physician providing test results |
| **Data Field** | **Medical Hospitalizations** |
| **Medical Hospitalizations** | If the person was not hospitalized recently for medical reasons, check None Reported |
| **Hospital** | If the person was hospitalized recently, indicate the hospital name and location for each hospital stay |
| **Date(s) of Service** | Record the date(s) of each hospitalization |
| **Reason (Medical Procedure, Acute Illness, Birth of Child, Etc.)** | Record the reason for each hospitalization. |

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| **Data Field** | **Unresolved Surgical Care Needs** |
| **Unresolved Surgical Care Needs** | Explain care needs relative to recently performed surgical procedures. |
| **Data Field** | **Complimentary Health Approaches** |
| **Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)?** | Indicate if the person utilizes any complimentary health approaches. If yes, describe. |
| **Does the person wish to consider using complimentary health approaches and want help finding a provider** | Indicate if the person would like to consider using complimentary health approaches and/or if they would like help finding a provider. If yes, describe. |
| **Data Field** | **Respiratory System** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Endocrine System** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Diabetes** | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Neurologic Disorder** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Movement Disorder** |
| **Movement Disorder** | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Immune System Disorders** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section.<br>If AIDS/HIV status is recorded DPH/DMH regulation requires that the form is kept separate from the regular medical record and secured unless a written authorization was obtained from the person served. |
| **Data Field** | **Bacterial/Viral Infections** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Visual Impairment** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Auditory Impairment** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Digestive/Urinary Conditions** |

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| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Dental Conditions** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Reproductive Health** |
| | Check all boxes that apply and complete requested details that represent person's medical status. If none reported, check no and skip to next section. |
| **Data Field** | **Advanced Directives in place** |
| | Check all boxes that apply. |
| **Data Field** | **Pain Assessment Screening** |
| | Indicate the person's reported level of pain today using zero to 10 point scale |
| **Does pain currently interfere with your daily activities?** | Check Yes or No. If yes, indicate the degree to which pain interferes with person's activities. |
| **Data Field** | **Ambulation** |
| | Check all boxes and complete requested details that represent person's medical status. |
| **Data Field** | **Dietary** |
| | Check all boxes and complete requested details that represent person's medical status. |
| **Data Field** | **Diseases of the Liver** |
| | Check all boxes and complete requested details that represent person's medical status. |
| **Data Field** | **Dermatologic Conditions** |
| | Check all boxes and complete requested details that represent person's medical status. |
| **Data Field** | **Cancer** |
| **Cancer** | Check Yes or No. If yes, indicate type of cancer and treatments received. |
| **Currently in remission** | Check Yes or No. If yes, indicate how long the person has been in remission (years/months). |
| **Data Field** | **Bone and Joint Conditions** |
| | Check all boxes that apply and complete requested details. If none reported, check no and skip to next section. |
| **Have these conditions led to:** | Check all boxes that apply. |
| **Data Field** | **Comments** |
| | Record any comments. |
| **Data Field** | **For Opiate Treatment Programs:** |
| | For Opiate Treatment Programs a specific comprehensive physical examination, completed by a medical professional, must be attached. |
| **Data Field** | **Comments, Recommendations or Referrals by Medical Reviewer:** |
| | If no referral needed, skip to signature and credential section. |
| **Data Field** | **Check Referral(s) Needed and Specify Action(s)** |

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| | Check all resources needed for referral. Specify reason for referral to provider. |
| **Data Field** | **Recommendation shared with person served** |
| | Check yes or no. If yes, record person's served response to recommendations. If no, indicate how recommendations will be shared with person served. |

| Data Field | Signatures |
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| **Person's Signature** (Optional, if clinically appropriate) | Signature of the person to be served by the agency indicating his/her understanding and acceptance of the treatment recommendation/assessed needs. |
| **Date** | Next to each signature record the date of the signature. |
| **Parent/Guardian Signature** (if appropriate) | |
| **Date** | Next to each signature record the date of the signature. |
| **Clinician/Provider – Print Name/Credential** | **Legibly print** name and credential(s) of person completing the Comprehensive Assessment. |
| **Date** | Next to each signature record the date of the signature. |
| **Supervisor – Print Name/Credential (if needed)** | If the diagnosis is rendered by a clinician other than the clinician printed above, then the clinician rendering the diagnosis must print his/her educational level and highest license level. |
| **Date** | Next to each signature record the date of the signature. |
| **Clinician/Provider Signature** | **Legible signature** of person completing the Comprehensive Assessment. |
| **Date** | Next to each signature record the date of the signature. |
| **Supervisor Signature (if needed)** | If the diagnosis is rendered by a clinician other than the clinician signed above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level. |
| **Date** | Next to each signature record the date of the signature. |
| **Psychiatrist/MD/DO** (if required) | This is a requirement for Opiate Treatment Programs. |