UNITY HEALING CENTER

HISTORY AND PHYSICAL EXAMINATION

To be completed by a Licensed Physician, Physician's Assistant, or Nurse Practitioner

(A Comprehensive Physical Exam Form May be Substituted in lieu of this form)

HISTORY

HIV Testing: Yes ________ No ________

Date and Results: ____

HIV Risk Factors: (Circle Factors): IV Drug Use Unprotected Sex

Other: ____

If resident is sexually active, are condoms routinely used? Yes ________ No ________

History of STI's: Yes__ No___ Please list current/previous

STI's:____

History of Hepatitis? Yes __ No ____ Type of Hepatitis: ______________

Allergies to food/medication: ______________________________

Type of reaction to each allergy listed:

____

Hospitalization (List dates and reasons): ______________________________

____

____

Surgical (List dates and reasons): ______________________________

____

____

Injuries (Past/Current): ______________________________

____

OB-GYN: Menarche: __________ Menstrual History/Problems: ______________

____

LMP: __________ Last PAP: __________ Gravida: _____ Para: __________

Contraception: ____

PHYSICAL EXAM

Vital Signs: SaO2_____P_____ T _____ R _____ BP ________

Height: __________ Weight: __________ BMI: __________

General Overall Condition: ______________________________

Speech Impairment: Yes _________ No ________ Describe: ______________

Vision: Left ______________ Right _____________
Hearing: Left ______________ Right _____________

HEENT:
Head: ____
Eyes: ____
Ears: ____
Nose: ____
Throat: ____
Teeth/Gums: ____
Neck: Thyroid: ____
Nodes: ____

Respiratory:
Cough:___________________Wheezing:______________________
Asthma: Yes___ No___ Mild___ Moderate___ Severe___
TB or TB exposure:______________ Date/Results of last PPD/TB Test: ____________________
Lung Sounds: ________________________
Respiratory Disease/Illness: ____

Cardiovascular:
Heart: ____
Pulses: ____
Vascular:____
History of Cardiac Diseases/Issues: Yes ___ No___ (Please explain below if answer is Yes)
Explanation: ____

Gastrointestinal:
Abdomen: ____
Constipation: Yes ___ No___
Diarrhea: Yes___ No___
Frequent Nausea/Vomiting: Yes ___ No___

Genitourinary:
Genitalia: (Females-Pelvic) ____
____
Rectum: ____

Integumentary:
Skin/Hair/Nails: ____
Injuries (Bruising/Cuts/Scrapes/Abrasions/etc.):______________________________ _____

Neuromuscular:

Back/Spine: ______________________________

Extremities: ______________________________

Cranial Nerves II-XII: ______________________________

Motor Strength: ______________________________

Cerebellar: ______________________________

Gait: ______________________________

Finger to Nose/Heel to Shin: ______________________________

Deep Tendon Reflexes: ______________________________

Sensation: ______________________________

CHILD/ADOLESCENT GROWTH & DEVELOPMENT:

During pregnancy, did the biological mother have any of the following: (select all that apply)

☐ Amniocentesis ☐ High Blood Pressure ☐ Vaginal Bleeding ☐ German measles
☐ Anemia ☐ High Fever ☐ Vaginal Infection ☐ Premature Labor
☐ Diabetes Mellitus ☐ Kidney Problems ☐ Other Infection ☐ Placenta Previa
☐ Emotional Problems ☐ No Prenatal Care ☐ Unknown ☐ Excessive Weight Gain
☐ None ☐ Other (specify)______________________________

During pregnancy, did the biological mother use any of the following: (select all that apply)

☐ Alcohol ☐ Prescription Drugs ☐ Street Drugs ☐ Unknown
☐ Tobacco ☐ Over the Counter Drugs ☐ None ☐ Other (specify)_____

Comments: ______________________________

____

____

Any problems with labor and delivery? ☐ No ☐ Yes (specify) ______________________________

Apgar Scores: 1 Minute:________ 5 Minutes: _______

Injuries	**Poisoning**	**Blood Disorders**
☐ Broken Bones	☐ Chemicals	☐ Anemia
☐ Stitches	☐ Lead	☐ Bleeding
☐ None	☐ None	☐ Bruising

Did the baby have any of the following after delivery: (select all that apply)

☐ Anemia ☐ Eye Problems ☐ Intracranial Bleed ☐ Trouble Sucking
☐ Apnea ☐ Fever/low temperature ☐ Jitteriness ☐ Multiple Pregnancy
☐ Birth Defects ☐ Hernia ☐ Physical Injury ☐ Use of Oxygen
☐ Blood Transfusions ☐ Hydrocephalus ☐ Seizures ☐ Ventilator
☐ Bradycardia ☐ Infection ☐ Surfactant ☐ Yellow Jaundice
☐ Cord around Neck ☐ Intensive Care ☐ Trouble Breathing ☐ None
☐ Other (specify) ______________________________

Developmental Milestones – did the child have delays on any of the following: (select all that apply)

- ☐ Rolling Over (2-6 mos)
- ☐ Sitting (6-12 mos)
- ☐ Standing (8-16 mos)
- ☐ Walking (8-16 mos)
- ☐ None
- ☐ Engaging Peers (24-36 mos)
- ☐ Toileting (24-36 mos)
- ☐ Dressing Self (24-36 mos)
- ☐ Feeding Self
- ☐ Sleeping Alone
- ☐ Tolerating Separation
- ☐ Playing Cooperatively
- ☐ Talking

Has the child had any of the following: (select all that apply)

Brain Disorders

- ☐ Confusion
- ☐ Headaches
- ☐ Coordination Problems
- ☐ Muscle Weakness
- ☐ Staring
- ☐ Tremors
- ☐ Tics (motor/vocal)
- ☐ Head injuries
- ☐ Seizures

Infections

- ☐ Chicken Pox
- ☐ Ear Infections
- ☐ Encephalitis
- ☐ High Fevers
- ☐ Measles
- ☐ Mumps
- ☐ Meningitis
- ☐ Pneumonia
- ☐ Sinus Infections

Hormone Problems

- ☐ Obesity
- ☐ Thyroid
- ☐ Early Puberty
- ☐ Late Puberty
- ☐ None
- ☐ Other (specify): ___

Muscle/Bone Problems

- ☐ None
- ☐ Other (specify): ___________
- ☐ Other (specify): ___________
- ☐ Other (specify): ___________
- ☐ Whooping Cough
- ☐ Spasticity
- ☐ Scoliosis

Heart/Lung Problems

- ☐ Asthma
- ☐ Chest Pain
- ☐ Murmur
- ☐ Surgery
- ☐ Congenital Heart Disease
- ☐ None
- ☐ Other (specify): ___________

GI Problems

- ☐ Constipation
- ☐ Diarrhea
- ☐ Soiling
- ☐ Vomiting
- ☐ None
- ☐ Other (specify): ____

Skin Disorders

- ☐ Acne
- ☐ Birth Marks
- ☐ Eczema
- ☐ Hair Loss
- ☐ None
- ☐ Other (specify): _____

Kidney Problems

- ☐ Bed Wetting
- ☐ Daytime Wetting
- ☐ Infections
- ☐ None
- ☐ Other (specify): ____ ____________________

Sensory Problems

- ☐ Auditory
- ☐ Tactile
- ☐ Visual
- ☐ None
- ☐ Other (specify): ____ ____________________

Other

- ☐ Birth Control
- ☐ Masturbation
- ☐ Promiscuity
- ☐ None
- ☐ Other (specify): ____ ____________________

Are immunizations up to date? ☐ Yes ☐ No (specify) ____

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<u>ASSESSMENT AND PLAN:</u>

Medical Diagnosis: ____

Overall Impression of General Assessment:

Clinical Laboratory Studies:

Plan: ____

Current Medications (Prescribed and OTC):

Medication	Dose	Quantity	How Often	Prescribing Provider

Note: Unity Healing Center is a Residential Youth Treatment Center for substance use. Residents will be in treatment for approximately 90 days. Please schedule any future critical appointments before treatment and other appointments after treatment.

Are there any physical restrictions? ______________________________________

________________________________ ________________________________

Medical Provider's Signature and Date **Print Medical Provider's Name & Degree**

Name of Clinic/Facility: ______________________________________

Mailing Address: ______________________________________

City, State, Zip Code: ______________________________________

Phone Number: ______________________Fax Number: ____________________