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: ________________
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<tr>
<th>Vision:</th>
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<td>Hearing:</td>
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**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/Scraps/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/preadoleSCent 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)
Unity Healing Center Physical Exam

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

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

Muscle/Bone Problems
- None
- Other (specify): __________
- Other (specify): __________
- Other (specify): __________

Heart/Lung Problems
- Asthma
- Chest Pain
- Murmur
- Surgery
- Congenital Heart Disease
- None
- Other (specify): __________

Kidney Problems
- Bed Wetting
- Daytime Wetting
- Infections
- None
- Other (specify): ___

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): ___

GI Problems
- Constipation
- Diarrhea
- Soiling
- Vomiting
- None
- Other (specify): ___

Sensory Problems
- Auditory
- Tactile
- Visual
- None
- Other (specify): ___

Skin Disorders
- Acne
- Birth Marks
- Eczema
- Hair Loss
- None
- Other (specify): ___

Other
- Birth Control
- Masturbation
- Promiscuity
- None
- Other (specify): ___

Are immunizations up to date?
- Yes
- No (specify) ___

ASSessment and Plan:
Medical Diagnosis: __________
Overall Impression of General Assessment:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Clinical Laboratory Studies:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Plan: _________________________________________________________________________

______________________________________________________________________________

Current Medications (Prescribed and OTC):

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<th>Medication</th>
<th>Dose</th>
<th>Quantity</th>
<th>How Often</th>
<th>Prescribing Provider</th>
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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: ________________________