Adult Health Assessment Survey

Client Name: _____ Client #: _____ Date: _____

Primary CSP Name: _____

Primary Care Physician/Clinic: _____ Date Last Seen: _____

PC Address: _____ Reason for last visit: _____

Please complete all questions. List "yes" only for items you are certain are true.

Medical History: (Check all that apply)	Current Treatment	Past Treatment	Name of physician or clinic providing treatment (if current)
Anemia	☐	☐	_____
Arthritis	☐	☐	_____
Blood Pressure Problem	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Epilepsy (seizures)	☐	☐	_____
Glaucoma	☐	☐	_____
Hearing Impairment	☐	☐	_____
Heart Problem	☐	☐	_____
HIV	☐	☐	_____
Liver Problem	☐	☐	_____
Respiratory Problem	☐	☐	_____
Sexual Difficulty	☐	☐	_____
Sexually Transmitted Disease	☐	☐	_____
Thyroid Problem	☐	☐	_____
Tuberculosis	☐	☐	_____
Ulcer	☐	☐	_____
Other (List)_____	☐	☐	_____
Other (List)_____	☐	☐	_____

List any hospitalizations (past year): Check here if none in the past year ☐

_____

List any major surgeries: Check here if no previous surgeries ☐

_____

List any allergies you have including medication allergies: Check here if no known allergies ☐

_____

List any developmental disorders you have had diagnosed: Check here if no developmental disorders ☐

_____

List any specific diet you are required to follow medically:

_____

Have you been abused sexually? ☐ yes ☐ no

Have you been abused physically? ☐ yes ☐ no

Are you currently in any pain? □ yes □ no

On a scale of 1 to 10, with 10 being unbearable, how would you rate your current level of pain? _____
What your the highest level of pain in the last 12 months? _____
What is your understanding of the cause of your pain? _____
_____
What methods do you use to manage your pain? _____

List all current medications (include over the counter meds and any supplements):

Medication Name	Strength	Reason You Take It	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check any of the following that applies to you:

	No use	Experimental Use	Regular Use
Alcohol	□	□	□
Amphetamines (such as speed, methamphetamine)	□	□	□
Caffeine (such as coffee, tea, colas)	□	□	□
Cannabis (marijuana)	□	□	□
Sedatives (such as sleeping pills)	□	□	□
Laxatives	□	□	□
Inhalants (such as glue, solvents)	□	□	□
Nicotine (such as cigarettes, cigars, nicorettes)	□	□	□
Opioids (such as heroin, methadone, codeine)	□	□	□
Cocaine (or “crack”)	□	□	□
Hallucinogens (such as LSD, PCP)	□	□	□
Other (List) _____	□	□	□

List any substance(s) above you have used by injection: _____ □ Not applicable
If so, have you shared needles with anyone? □ yes □ no
Have you had any blood transfusion(s)? □ yes □ no

For female clients only: Please answer each item.

Are you pregnant currently?	□yes	□ no
Are you having any difficulty with your periods?	□ yes	□ no
Have you had a hysterectomy?	□ yes	□ no
Have you had a tubal ligation?	□ yes	□ no
Have you completed menopause?	□ yes	□ no

Recommendation(s) for service provider (to be completed by M.D. or R.N. only):
□ continue follow-up for current medical problems listed
□ none
□ assist client with medical appointment for evaluation of _____(if not already done)
□ arrange for additional evaluation of substance use
□other_____
_____

Client Signature: _____Client date of birth: _____

Reviewer’s signature: _____ Date Reviewed:_____