Client Name _____ ID Number _____

CRBH Health Screening
Paper Back Up

Rev. 09/20/19

Date: ☐ Initial or ☐ Update Evaluation

Physical address line 1:
Physical address line 2:
City: Zip code:
State:

Problem with eyes, ears, nose, or throat? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have dizziness, fainting, headaches, fatigue, seizures, or head injuries? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have chest pain, heart attacks, or other heart disorders, HBP, Stroke, blood disease, hardening of the arteries?
☐ Yes ☐ No ☐ N/A
If yes, explain:

Positive family history of diabetes, heart disease, HBP, stroke, seizures, respiratory problems, blood disease, cancer, genetic D/O, arthritis, etc.? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have cough, shortness of breath, asthma, COPD, or other respiratory problems? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have ulcers or other stomach problems? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have anemia, thyroid, pancreas, liver, or jaundice problems? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have diabetes or hypoglycemia? ☐ Yes ☐ No ☐ N/A
If yes, explain:

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Do you have a disorder of the muscles, bones, back, or joint arthritis? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have bowel or urinary problems? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Genetic disorders or birth defects? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Do you have disorders of the skin, tumors, cancer, or severe skin infections? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Problem with male/female organs? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Venereal (sexually transmitted) disease? ☐ Yes ☐ No ☐ N/A
If yes, explain:

Are you sexually active? ☐ Yes ☐ No ☐ N/A

Are you menopausal? ☐ Yes ☐ No ☐ N/A

Age of menstruation onset: _____ How many days is your period? _____

How often is your period? _____ Approximate date of your last period? _____

Pregnancy history:

Do you have tuberculosis, hepatitis, AIDS, or other infectious diseases? ☐ Yes ☐ No ☐ N/A
If yes, explain:

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Do you spit up blood? ☐ Yes ☐ No ☐ N/A

If yes, explain:

Do you have drenching night sweats? ☐ Yes ☐ No

If yes explain:

Do you drink alcohol, or use non-prescription/street drugs (frequency/amount/duration of use)?

☐ Yes ☐ No ☐ N/A

If yes, explain:

Do you have or had DT's or Blackouts? ☐ Yes ☐ No ☐ N/A

If yes, explain:

Do you use tobacco? ☐ Yes ☐ No ☐ N/A

If yes, what form, how much, and how often:

Do you have a family history of drug abuse, depression, major mental/emotional problems, or other major illness?

☐ Yes ☐ No ☐ N/A

If yes, explain:

Are you sleeping well? ☐ Yes ☐ No ☐ N/A

If no, explain:

Do you use alcohol/drugs/medications to help you sleep? ☐ Yes ☐ No ☐ N/A

If yes, explain:

Major health problems, hospitalizations, visits to the ER, not listed above? ☐ Yes ☐ No ☐ N/A

If yes, explain:

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Are you currently under a doctor's care? ☐ Yes ☐ No ☐ N/A

If yes, explain:

Nutrition Screening

Do you have any food allergies? ☐ Yes ☐ No ☐ N/A

If yes, explain

Are you required to be on a special diet? ☐ Yes ☐ No ☐ N/A

If yes, explain

Do you have any dental issues that impact your ability to eat? ☐ Yes ☐ No ☐ N/A

If yes, explain

Approximate date of last dental exam _____

Dentist Name and address

Do you use diet pills, laxatives or diuretics for weight loss? ☐ Yes ☐ No ☐ N/A

If yes, explain

Do you restrict eating for any reason? ☐ Yes ☐ No ☐ N/A

If yes, explain

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Do you binge eat? ☐ Yes ☐ No ☐ N/A
If yes, explain

Do you make yourself throw up after eating? ☐ Yes ☐ No ☐ N/A
If yes, explain

Change in appetite or weight in last 3 months? ☐ Yes ☐ No ☐ N/A
If yes, explain

Have you had a weight loss or gain of 10 pounds or more in the last 3 months? ☐ Yes ☐ No ☐ N/A
If yes, explain

Clinical summary of nutritional issues **(for office use only)**

Referral made? **(Office use only)** ☐ Yes ☐ No ☐ N/A

(If any issues identified, refer to primary care for further assessment/treatment)

If issues were identified and referral was not made, please explain include: referred Where? When?

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Have you gone more than one day without eating any food, except when ill? ☐ Yes ☐ No ☐ N/A

Do you have additional allergies? (ex. Medication, environmental, etc.) ☐ Yes ☐ No ☐ N/A

Approximate date of last Dr. visit or physical exam:

Was a ROI signed to obtain current physical from PCP? ☐ Yes ☐ No

Has P.E. form been given to client? ☐ Yes ☐ No

If physical exam form was given, please document below.

Physician referral, physical exam waived? ☐ Yes ☐ No ☐ N/A

Date of last tetanus injection:

Date of last TB skin test:

PCP Name and Address

Immunization records (clients under 18 years of age). If no, request a copy? ☐ Yes ☐ No ☐ N/A

Preferred pharmacy name and address:

Pain Assessment

Client has-

☐ No Pain ☐ Pain

Physical Diagnosis-

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Location of Pain-

Intensity of Pain

- ☐ 0-No Pain
- ☐ 2-Hurts a Little
- ☐ 4-Hurts a Little More
- ☐ 6-Hurts evan More
- ☐ 8-Hurts Whole Lot
- ☐ 10-Hurts Worst

_____ Present Pain _____ Worst Pain Gets _____ Best Pain Gets _____Acceptable Level of Pain

What Relieves Pain-

What Causes or Increases Pain

Effects of Pain-

Other Comments:

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Plan **(This portion to be filled out by clinician)**-
If present pain is rated at 6 or greater, a referral must be made for treatment. Please indicate referral made, or reason for not making referral.)

Emergency Contact Name-

Emergency Contact Phone #-

This section office use only
Clinician summary of findings/plan:

Clinician Signature _____

Doctor/Psychiatrist Signature _____