Patient name ___________________________________

MR# _________

HEALTH, NUTRITION, AND PAIN ASSESSMENT

Please check "Yes" if you have had any of the following conditions. If "yes" please indicate if you have been treated for the condition. Note any additional information you would like the physician or therapist to know regarding each condition.

CONDITION	YES	TREATED	OTHER INFORMATION	CONDITION	YES	TREATED	OTHER INFORMATION
Allergies to medications				High Blood Pressure			
Medication Sensitivity				Kidney/bladder			
Anemia				Polio			
Arthritis				Rheumatism			
Asthma				Rheumatic Fever			
Bleeding Ulcers				Skin Condition			
Cancer or Tumor				Stomach/Intestinal Ulcer			
Diabetes				Thyroid Disease			
Glaucoma				Tuberculosis			
Gout				Headache			
Epilepsy/Seizure				Dizziness			
Heart Problems, specify				Head Trauma/Injury			
Head Injury				Vision Problems			
Hearing Aids				Ankle swelling			
Sore Throat				Chest/pain pressure			
Swollen Glands				Shortness of breath			
Dental Problems				Cough			
Dentures				Bloody Sputum			
Bedwetting				Emphysema			
Blood in Urine				Hoarseness			
Vaginal Discharge				**Please indicate if you had any of the following changes and or difficulties.**			
Urinary Problems, specify				Low/High Energy		Washing	Falls
Menstrual difficulty				Sleep Issues		Dressing	Rash
Irregular/Pacing/ Racing Heartbeat				Walking/assistive devices		Talking	Hair Changes

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HEALTH, NUTRITION, AND PAIN ASSESSMENT

Patient name ___________________________________

MR# _________

Condition	Yes	Other Information	Condition	Yes	Other Information
Difficulty Chewing			Severe Nausea/vomiting/diarrhea for great than 5 days		
Difficulty Swallowing			Eating inedible substances		
Weight Changes (5% in a month, 10% in 6 months)			Obesity (BMI greater than 35)		
Recent change in diet/appetite			Modified Die or Therapeutic Diet		
Current Diagnosis of Anorexia			Medications that warrant a diet instruction: Lithium, Coumadin, Lasix, Cholesterol Lowering Agents		
Current Diagnosis of Bulimia			Gastric Bypass		
Dialysis			Pregnancy		

Primary Care Physician____

Address____

Phone___________________________ Date of last physical___________________________________

Please circle your answers to the following questions.

Have you ever been in counseling or therapy? Yes No
If yes, give dates and reasons____

Have you ever been hospitalized? Yes No
If yes, give dates and reasons ____

Do you have any history of pain management for a chronic condition? Yes No

Do you have an advance directive? Yes No

Do you have a Mental Health advance directive? Yes No
If no, do you need help in completing either of these documents? Yes No

Are you currently experience any pain? Yes No
If yes, please indicate severity 1-10 (10 being most severe), location, current treatment and medications for pain being taken.__________
____

Is there any known history of infections caused by drug resistant organisms? Yes No
If yes, please describe ____

____ _______________________
Patient / Guardian Signature Date

Patient name ___________________________________

MR# _________

HEALTH, NUTRITION, AND PAIN ASSESSMENT

This form reviewed with client. Yes No

Clinician Signature_____________________________ Date/Time____________________________

- If answers indicate current, untreated medical and/or pain problems
- If the date of the last physical exam is greater than one year ago, appropriate referrals to be made as follows

Ask personal physician to repeat physical examination. ____
Recommend follow up with (please circle)* Physician *Nutrition * Neurologist *Rehab/falls *Pain Management
Follow up for ____
Clinician/MD Signature_______________________________________ Date/Time_________________________
Please review the Health, Nutrition, and Pain Screen in detail. Has there been any changes in your health/nutrition, plain/falls in the last year? (Circle One) Yes No
If yes, please explain
____
____
____

Recommend follow up with (please circle)* Physician *Nutrition * Neurologist *Rehab/falls *Pain Management
Follow up for ____
Clinician/MD Signature_______________________________________ Date/Time_________________________
Please review the Health, Nutrition, and Pain Screen in detail. Has there been any changes in your health/nutrition, plain/falls in the last year? (Circle One) Yes No
If yes, please explain
____
____
____

Recommend follow up with (please circle)* Physician *Nutrition * Neurologist *Rehab/falls *Pain Management
Follow up for ____
Clinician/MD Signature_______________________________________ Date/Time_________________________
Please review the Health, Nutrition, and Pain Screen in detail. Has there been any changes in your health/nutrition, plain/falls in the last year? (Circle One) Yes No
If yes, please explain
____
____
____

Recommend follow up with (please circle)* Physician *Nutrition * Neurologist *Rehab/falls *Pain Management
Follow up for ____
Doctor Signature_______________________________________ Date/Time_________________________
Please review the Health, Nutrition, and Pain Screen in detail. Has there been any changes in your health/nutrition, plain/falls in the last year? (Circle One) Yes No
If yes, please explain
____
____
____