

**Mid-Ohio Psychological Services, Inc.  
Physical Health Assessment**

Legal Name \_\_\_\_\_ Date \_\_\_\_\_

Name you prefer \_\_\_\_\_ Age \_\_\_\_\_

Birth date \_\_\_\_\_ Gender \_\_\_\_\_ M \_\_\_\_\_ F

Race:  White  Black  Asian  Am. Indian  Hispanic  Other \_\_\_\_\_

Name of family physician or clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Date last seen by physician: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Are you currently under a physician's treatment?  Yes  No

Condition(s) you are being treated for \_\_\_\_\_

**List all medications you are currently taking or have discontinued within the last month (30 days) for physical and/or emotional reasons. Include birth control pills and over the counter medications:**

None taken

Name of Medication	Dosage	How Often Taken	Who told you to take this medication?	How long have you taken it?	Is it a Prescription Medication?

**Who administers these medications to you?**

Self

Other: \_\_\_\_\_

**What other kinds of medications have you taken in the past?**

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**Allergies:**

**Allergies to Medication**  Yes  No

**If yes, which medications:** \_\_\_\_\_

**Type of reaction:** \_\_\_\_\_

**Other allergies (food, environment, etc)** \_\_\_\_\_

**Type of reaction:** \_\_\_\_\_

**YOUTH:**

**Immunizations** - Has client had or been immunized for the following diseases? Please check.

- |                                      |                                     |   |                                      |
|--------------------------------------|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> German Measles | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Mumps      | <input type="checkbox"/> Polio          | <input type="checkbox"/> Small Pox   |
| <input type="checkbox"/> Tetanus     | <input type="checkbox"/> Other:     |   |                                      |

**Immunizations Within the Past Year:** \_\_\_\_\_

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**Pre-natal exposure to alcohol, tobacco, or other drugs:** \_\_\_\_\_

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**FEMALES:**

**Are you currently pregnant?**  Yes  No **How far along?** \_\_\_\_\_

**Breast-feeding?**  Yes  No

**Have you ever had an abortion?**  Yes  No **How many?** \_\_\_\_\_

**Have you ever had a miscarriage?**  Yes  No **How many?** \_\_\_\_\_

**Is your menstrual cycle**  Regular  Irregular

**MALES & FEMALES:**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much? \_\_\_\_\_

Do you use street drugs?  Yes  No How much? \_\_\_\_\_  
What kind? \_\_\_\_\_

Have you ever abused prescription medications?  Yes  No

Describe: \_\_\_\_\_

Do you drink coffee or other caffeine products?  Yes  No

How much? \_\_\_\_\_

Have you ever been sexually abused?  Yes  No

Describe Briefly:

Have you ever been physically abused?  Yes  No

Describe Briefly:

Are you sexually active?  Yes  No

Are you having any difficulties performing sexually?  Yes  No

Explain:

Aids to daily living:

- Glasses/Contact lens
- Hearing Aid
- Dentures/Partial
- Prosthetics

Other significant medical information or observations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Significant medical history in your biological family (ie. History of psychiatric problems, chronic medical problems, etc). \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**List past surgeries/injuries/hospitalizations and dates:**

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**Describe any physical or developmental disabilities that you may have (ie. Were you ever in special education classes, have you ever had a significant physical injury, are you on SSD?):**

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**In the last year, how many times have you:**

\_\_\_\_\_ **Been Hospitalized**  
\_\_\_\_\_ **Been seen at the Emergency Room**  
\_\_\_\_\_ **Received Services at an outpatient clinic**

\_\_\_\_\_ **Seen your regular doctor**  
\_\_\_\_\_ **Been to a dentist**

Please mark the following with a (P) if you have had any problems with the following in the past and with a (C ) if you currently have problems with the condition :

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Bronchitis                  | <input type="checkbox"/> Nerve Problems                    | <input type="checkbox"/> Gall Bladder Disease      |
| <input type="checkbox"/> HIV+                | <input type="checkbox"/> Blackouts                   | <input type="checkbox"/> Heart Failure                     | <input type="checkbox"/> Migraine Headaches        |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Liver Disease                     | <input type="checkbox"/> Kidney Disease/<br>Stones |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Jaundice                    | <input type="checkbox"/> Low Blood Pressure                | <input type="checkbox"/> Alcohol/Drug Abuse        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Psychiatric Problems      |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Seizures/Epilepsy                 | <input type="checkbox"/> Panic Attacks             |
| <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Gonorrhea/Syphilis        |
| <input type="checkbox"/> Colitis             | <input type="checkbox"/> Thyroid/Goiter              | <input type="checkbox"/> Rheumatic Fever                   | <input type="checkbox"/> Herpes/Venereal           |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Urine Infections                  | <input type="checkbox"/> Warts/Crabs               |
| <input type="checkbox"/> Vision<br>Problems  | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Frequent Cough                    | <input type="checkbox"/> Poor Circulation          |
| <input type="checkbox"/> Over<br>Weight      | <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Bleeding Tendencies               | <input type="checkbox"/> Chest Pains               |
| <input type="checkbox"/> Memory<br>Problems  | <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Loss of Bladder/<br>Bowel Control | <input type="checkbox"/> Palpitations              |
| <input type="checkbox"/> Weight<br>Loss/Gain | <input type="checkbox"/> Blood Disease               | <input type="checkbox"/> Sinus Problems                    | <input type="checkbox"/> Poor Appetite             |
| <input type="checkbox"/> Back Pain           | <input type="checkbox"/> Rashes or<br>Skin Condition | <input type="checkbox"/> Colostomy/Urostomy                | <input type="checkbox"/> Overeating                |
| <input type="checkbox"/> Numbness            | <input type="checkbox"/> Nightmares                  | <input type="checkbox"/> Hallucinations                    | <input type="checkbox"/> Constipation              |
|  | <input type="checkbox"/> Confusion                   | <input type="checkbox"/> Difficulty Sleeping               | <input type="checkbox"/> Diarrhea                  |
|  | <input type="checkbox"/> Hard of Hearing/<br>Deaf    | <input type="checkbox"/> Muscle Weakness                   | <input type="checkbox"/> Impotency/Frigidity       |

\_\_\_\_\_  
Client Signature \_\_\_\_\_ Date

Client refused to complete this form. \_\_\_\_\_ Date  
Staff Initials

Client refused to sign release to gather medial information \_\_\_\_\_ Date  
Staff Initials

**Mid-Ohio Psychological Services, Inc. use only**

Physical exam warranted?  Yes  No

If pregnant, was an effort made to ensure prenatal care? (Explain on back of form)  Yes  No

Did the client sign a release to communicate with and/or obtain a PHA from a physician:  Yes  No

Physician referral made to: \_\_\_\_\_

Other instructions/concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of RN or Physician \_\_\_\_\_ Date