Avatar ID: _____

Client Health Screen

Client Name _____ **Today's Date** _____

Has the client had the following examinations in the past year:

Physical Exam?	☐ Yes	☐ No	Date of Last Physical Exam	_____
Dental Exam?	☐ Yes	☐ No	Date of Last Dental Exam Date	_____
Visual Exam?	☐ Yes	☐ No	Date of Last Vision Exam	_____

Residential/IHP Clients Only

Height: _____

Weight: _____

If a physical examination has **not** be completed within the last year, please make an appointment with a medical provider (excludes OP Campus). If you need assistance locating a medical provider, please make the assigned staff member aware of your need.

Client Health Conditions	N/A	Past Issue	Still Exists	Comment	Client Health Conditions	N/A	Past Issue	Still Exists	Comment
Allergy to:									
Environment/ Other	☐	☐	☐		Hearing Loss	☐	☐	☐	
Food	☐	☐	☐		Heart Problems	☐	☐	☐	
Medication	☐	☐	☐		Migraines/ Chronic Headaches	☐	☐	☐	
Asthma	☐	☐	☐		Neurological Disorder	☐	☐	☐	
Bladder/ Urinary	☐	☐	☐		Reproductive Concerns	☐	☐	☐	
Cancer	☐	☐	☐		Respiratory Infections	☐	☐	☐	
Constipation/ Diarrhea	☐	☐	☐		Seizures	☐	☐	☐	
Dental Problems	☐	☐	☐		Sexually Transmitted Infection	☐	☐	☐	
Diabetes	☐	☐	☐		Sleep Problems	☐	☐	☐	
Ear/ Vision Problems	☐	☐	☐		Sore Throats/Tonsillitis	☐	☐	☐	
Eczema/Skin Issues	☐	☐	☐		Stomach Aches	☐	☐	☐	
Epilepsy	☐	☐	☐		Unexplained Fever	☐	☐	☐	
Fainting	☐	☐	☐		Other	☐	☐	☐	
Head Injury	☐	☐	☐						

List significant injuries, hospitalizations or surgeries:

Has the client…	N/A	Past Issue	Last 3 Months	Still Exists	Comment
Experienced any unresolved physical pain or discomfort?	☐	☐	☐	☐	
Had any infectious diseases such as MRSA, hepatitis, tuberculosis, meningitis, rubella, small pox, mumps, chicken pox, pneumonia, or any other?	☐	☐	☐	☐	
Had special nutritional needs?	☐	☐	☐	☐	
Experienced any recent weight gain or loss of 10 pounds or more?	☐	☐	☐	☐	
Had changes in eating habits, such as: decrease in food intake and/or appetite, bingeing, self-induced vomiting?	☐	☐	☐	☐	
Had exposure to second-hand smoke and/or nicotine vapor?	☐	☐	☐	☐	
Been exposed to lice, scabies and/or bed bugs?	☐	☐	☐	☐	
Had unprotected sex?	☐	☐	☐	☐	

STAFF USE ONLY:

	N/A	Yes	No
For any health conditions and/or diseases still existing, is the client receiving medical treatment or follow-up?	☐	☐	☐

If "**No**", please explain: _____

Staff Recommendations: ☐ Complete Yearly Physical Exam ☐ Follow-up with PCP ☐ Follow-up with Specialist

☐ Other (explain) _____

Staff Signature _____ **Date Reviewed:** _____

By signing you are verifying the information above has been reviewed and any identified needs for medical follow up, including the need for a physical examination, have been discussed and reviewed with the client and/or parent/guardian.