COMPREHENSIVE PSYCHIATRY GROUP, INC.

PATIENT MEDICAL HISTORY & PHYSICAL SCREENING

Patient Name _____ ☐ Male ☐ Female _____ Height _____ Weight

Current Health Status (check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

KNOWN ALLERGIES (Medicine) _____
(Other) _____

ADVERSE REACTIONS _____

Current Medications (list medications & condition prescribed for) _____
_____
_____

PRIMARY PHYSICIAN _____ **DATE OF LAST PHYSICAL EXAM**_____

Vaccinations: ☐ Smallpox ☐ DPT ☐ MMM ☐ MMM Booster
☐ Tetanus (last dose) _____ ☐ Hepatitis B ☐ Other _____

NUTRITIONAL ASSESSMENT

Are you currently on any **special diet?**
☐ No
☐ Low Salt
☐ Diabetic
☐ Other_____

Experienced any recent **weight change?**
☐ No
☐ Loss of _____lbs.
☐ Gain of _____lbs.

Rate your **appetite** ☐ Good ☐ Fair ☐ Poor

Is this a **change** from the usual? ☐ No ☐ Yes Explain _____

Meal Consumption:					
	Breakfast	☐ Good	☐ Fair	☐ Poor	☐ NA
	Lunch	☐ Good	☐ Fair	☐ Poor	☐ NA
	Dinner	☐ Good	☐ Fair	☐ Poor	☐ NA

Snacking Habits (what do you eat & when?) _____

Ever treated for **growth problems**? ☐ Now ☐ Past ☐ NA

Ever diagnosed with an **eating disorder** ? ☐ Now ☐ Past ☐ NA

SYMPTOM REVIEW / MEDICAL CONDITIONS

Indicate Below ONLY what is applicable

	Now	Past		Now	Past		Now	Past
Food Cravings	☐	☐	Heart Attack	☐	☐	Itching / Rash	☐	☐
Sleep Difficulty	☐	☐	Chest Pain	☐	☐	Jaundice	☐	☐
Headaches	☐	☐	Stroke	☐	☐	Excessive Sweating	☐	☐
Migraine / Tension	☐	☐	Nausea / Vomiting	☐	☐	Chronic Pain	☐	☐
Seizures	☐	☐	Abdominal Pain	☐	☐	Diabetes / Insulin	☐	☐
Dizziness	☐	☐	Heartburn	☐	☐	Asthma	☐	☐
Blackouts	☐	☐	Diarrhea	☐	☐	Alcoholism	☐	☐
Anxiety	☐	☐	Constipation	☐	☐	Drug Abuse/Addiction	☐	☐
Depression	☐	☐	Irregular Bleeding	☐	☐	Neurological Disease	☐	☐
Eye Problems	☐	☐	Painful Menstruation	☐	☐	Irritable Bowel / Colitis	☐	☐
Hearing Problems	☐	☐	Vaginal Discharge	☐	☐	Fatigue / Exhaustion	☐	☐
Ear Infections	☐	☐	Breast Lumps	☐	☐	Grinding Teeth	☐	☐
Sinus Infections	☐	☐	Burning Urination	☐	☐	Stiff / Painful Neck	☐	☐
Frequent Nose Bleeds	☐	☐	Penis Discharge	☐	☐	Thyroid Problems	☐	☐
Speech Difficulties	☐	☐	Bladder Infections	☐	☐	Kidney Disease	☐	☐
Swallowing Difficulties	☐	☐	Arthritis	☐	☐	Cancer	☐	☐
Shortness of Breath	☐	☐	Joint Pain / Swelling	☐	☐	(Type):		
Persistent Cough	☐	☐	Tumors	☐	☐	Bed-wetting	☐	☐
Smoker # Packs Day	☐	☐	Paralysis	☐	☐	Soiling	☐	☐
High Blood Pressure	☐	☐	Loss of Sensation	☐	☐	Ticks / Twitches	☐	☐
			Hair Pulling / Twisting	☐	☐			

REPRODUCTIVE HEALTH

List age of Onset for Puberty _____ ☐ NA Menopause _____ ☐ NA

# of Pregnancies _____ # of Births _____ # of Miscarriages _____

# of Stillborn _____ # of Terminations _____

_____
Patient Name

SURGERIES / HOSPITALIZATIONS

REASON	YEAR	AGE	REMARKS
1.			
2.			
3.			
4.			

FAMILY MEDICAL HISTORY

(Note relationship: Mother, Father, Maternal Grandmother, Uncle etc.)

PROBLEM	YES	NO	WHOM	PROBLEM	YES	NO	WHOM
Alcohol / Drugs	☐	☐		Seizures	☐	☐	
Cancer	☐	☐		Hypertension	☐	☐	
Diabetes	☐	☐		Heart Problems	☐	☐	
Depression	☐	☐		Stroke	☐	☐	
Suicide	☐	☐		Thyroid	☐	☐	
Anxiety	☐	☐		Obesity	☐	☐	
Psychiatric Care	☐	☐		Arthritis	☐	☐	
Allergies	☐	☐		Other	☐	☐	

Please list any additional significant information including past medical diagnoses & treatment

_____

_____

Completed by: (Patient / Parent Name)_____ Date _____

TO BE COMPLETED BY THE REVIEWER

Reviewed By _____ Date _____

Additional Information Needed ☐ NO ☐ YES

☐ PATIENT IS RECOMMENDED TO FOLLOW UP WITH PEDIATRICIAN / PRIMARY CARE PHYSICIAN FOR EVALUATION & TREATMENT OF _____
(Physical / Medical Condition or Symptom(s)

☐ NA

_____
Patient Name

CHILD / YOUTH PHYSICAL HEALTH ASSESSMENT

Please tell us if you now have or ever had concerns about your child's functioning in any of the following areas:

- **motor** development ☐ NO ☐YES _____
  (please specify what your concern is / was)
- **sensorimotor** functioning ☐ NO ☐YES _____
  (please specify what your concern is / was)
- **speech** functioning ☐ NO ☐YES _____
  (please specify what your concern is / was)
- **hearing** functioning ☐ NO ☐YES _____
  (please specify what your concern is / was)
- **language** functioning ☐ NO ☐YES _____
  (please specify what your concern is / was)
- **visual** functioning ☐ NO ☐YES _____
  (please specify what your concern is / was)
- **immunization** status ☐ NO ☐YES _____
  (please specify what your concern is / was)
- **oral health** & hygiene ☐ NO ☐YES _____
  (please specify what your concern is / was)

Parent is recommended to follow up with a specialist for additional in-depth screening / assessment for

- ☐ motor development
- ☐ sensorimotor functioning
- ☐ speech functioning
- ☐ hearing functioning
- ☐ language functioning
- ☐ visual functioning
- ☐ immunization status
- ☐ oral health

☐ NA to all of the above – no external referrals warranted

_____
Patient Name