DAUPHIN COUNTY WORK RELEASE CENTER
HEALTH ASSESSMENT FORM

NOTE: This form must be completed, signed, & dated by a licensed medical provide.

Date of Assessment: _____

Patient Full Name: _____

Date of Birth: _____ **SSN: _____**

Insurance Information

Name of Health Insurance Co. _____ Policy#: _____

Group No: _____ Are Referrals Needed for Care: Yes_____ No_____

MEDICAL HISTORY

Review of System – Specify (Y) Problem in Comment Section:

Y	N	System	Comment
		Headache	
		Seizures	
		Blackouts	
		DT's	
		Skin	
		Hearing	
		Ears	
		Vertigo	
		Vision	
		Speech	
		Dental	
		Chewing Problem	
		Swallowing	
		Joint Problems	
		Muscle	
		Ulcers	
		Gallbladder	
		Hepatitis & Type	
		Hemorrhoids	
		Thyroid	
		Diabetes	
		Allergies	
		Hay Fever	
		Asthma	
		Pneumonia	
		Heart Disease	
		Hypertension	
		Edema Swelling	

Y	N	System	Comment
		Anemia	
		Bleeding	
		Bruising	
		Arthritis	
		Gout	
		Back Pain	
		Kidney/bladder	
		Gonorrhea	
		Chlamydia	
		Syphilis	
		Herpes	
		Crabs/Lice	
		HIV/AIDS	
		Prostate	
		Hernia	
		Breast	
		Vaginal Discharge	
		Menarche Age	
		LMP / Duration	
		Cycle / Flow	
		Pregnancies	**G: P:**
		Miscarriages/Abortions	
		Pregnancy Complications	
		Mammogram Date:	
		Contraceptive Use/Type	
		UTI / Pelvic Infections	
		Pregnant Now?	
		Pregnant Test?	**(+) (-)**

Any Personal Medical Devices (assistive/diagnostic/etc.**) Needed** *or* **Other Problems/Chronic Conditions:**

_____

_____

_____

_____

Tuberculosis Testing (*MUST Have Test COMPLETED/Read With-in 90 Days of Report Date*):

Previous Testing: Yes: _____ No: _____ Results: _____mm

Past Positives: Date: _____ Location: _____ **(***Past Positives MUST be verified***)**

Date PPD Planted	Nurses Initials	Date PPD Read	Nurses Initials	Reaction 10mm or > = CXR	CXR Date	CXR Results
				MM		

Immunizations with Date of Last Vaccine/Dose *(If Known)*:

COVID-19: _____ Flu: _____ Hepatitis B: _____ Rubella: _____

Pneumovax: _____ Tetanus: _____ (Other: _____ Date: _____)

Vital Signs at Time of Assessment:

Blood Pressure: _____ Temperature: _____ Pulse: _____

Respiration: _____ Height: _____ Weight: _____

Any Psychiatric, Mental Health and/or Intellectual Disabilities Concerns: Yes ☐ No ☐

If Yes, explain: _____

Physical: Mark "N" if normal and "A" if abnormal in the box in front of the appropriate area and explain abnormalities.

N/A		Comments	N/A		Comments
	Alert, oriented, co-op			Upper Ext.	
	Head, Scalp, face			Pulses	
	Eyes (EOMI, PERRLA)			Spine	
	Eyes (Sclera, Trauma)			Lower Ext.	
	Ears			Feet	
	Nose Lips, Gums, Teeth			GU System	
	Neck (masses, supple)			Lymph	
	Thorax			Skin	
	Lungs			Gait Balanced	
	Heart			HEARING	AD: AS: AU:
	Abdomen (GI)			VISION	OD: OS: OU:

Currently on any **PAIN Medication:** Yes ☐ No ☐ **If Yes,** Name **&** Dosage**:** _____

Currently prescribed any **BENZOS (***Benzodiazepines***):** Yes ☐ No ☐ **If Yes,** Name **&** Dosage**:** _____

Currently on any **ADHD Medication:** Yes ☐ No ☐ **If Yes,** Name **&** Dosage**:** _____

Currently on ANY OTHER **Medication:** Yes ☐ No ☐ **If Yes, (***List* ALL *Medication***)** Name**,** Dosage**, &** Duration On**:**

★ **MEDICATION (***includes but not limited to***) NOT PERMITTED:** ADHD**,** Benzos**,** Narcotics**,** Gabapentin**,** Seroquel**, &** Wellbutrin ★

_____

_____

_____

_____

Any recommended follow-up care: Yes ☐ No ☐ **Any scheduled follow-up treatment:** Yes ☐ No ☐

If Yes, Where: _____ Date: _____ Time: _____

Provider Name (*Printed***):** _____ **License #:** _____

Signature: _____ **Specialty:** _____

Primary Care Physician: _____ Telephone: _____

Address: _____