Apex Downriver Behavioral Health

PHYSICAL HEALTH

Your current physician:

_____

Name *Address* *Phone Number*

Date last seen by your physician: _____

Reason for seeing your physician: _____

_____

Check all that apply and describe below:

[ ] Aids
[ ] Alcoholism
[ ] Abdominal Pain
[ ] Allergies
[ ] Anemia
[ ] Appendicitis
[ ] Arthritis
[ ] Asthma
[ ] Bronchitis
[ ] Bed Wetting
[ ] Cancer
[ ] Chest Pain
[ ] Chronic Pain
[ ] Colds/Coughs
[ ] Constipation
[ ] Chicken Pox
[ ] Diabetes
[ ] Drug Abuse
[ ] Diarrhea
[ ] Epilepsy
[ ] Ear Infections
[ ] Eating Problems
[ ] Fainting
[ ] Fatigue
[ ] Frequent Urination
[ ] Headaches
[ ] Hearing Problems
[ ] Hepatitis
[ ] High Blood Pressure
[ ] Kidney Problems
[ ] Measles
[ ] Mononucleosis
[ ] Mumps
[ ] Menstrual Pain
[ ] Neurological Disorder
[ ] Nausea
[ ] Nose Bleeds
[ ] Pneumonia
[ ] Sore Throat
[ ] Scarlet Fever
[ ] Sinusitis
[ ] Small Pox
[ ] Stroke
[ ] Sexual Problems
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Toothache
[ ] Thyroid Problems
[ ] Vision Problems
[ ] Venereal Disease
[ ] Vomiting
[ ] Whooping Cough
[ ] Sleep Problems
[ ] Dental Problems
[ ] Dizziness
[ ] Rheum. Fever
[ ] Other

Explain: _____

Do you smoke? Yes____ No_____

If yes, how often? _____

If yes, how much?_____

Current medications being taken:

1) _____ Dosage/Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical reasons? [ ] Yes [ ] No

Hospital	Mo / Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems you experience:

_____

_____

_____

Are you currently pregnant? [ ] No [ ] Yes If so, are you obtaining prenatal care? [ ] No [ ] Yes

Describe any important medical history, chronic ailments, or other health problems you experience:

_____

_____

_____

Client/Parent signature _____ Date _____

Based on the assessment (check one):

[ ] No further action required

[ ] Refer to primary care physician

[ ] Refer to urgent care/emergency room

Physical health was reviewed with client: **Yes ___** **No ____**

Practitioner signature _____ Date _____

Apex Downriver Behavioral Health

Nutrition Assessment

Client Name: _____

Date: _____

Read the statements below. Circle the number in the "Yes" column for those that apply to you.
Add the circled numbers to get your total nutritional risk score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than two meals a day.	3
I eat few fruits or vegetables, or milk products.	2
I have three or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need	4
I eat alone most of the time.	1
I take three or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten pounds in the last six months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
TOTAL	

Nutritional Health Score

0-2 *Good*
3-5 *Moderate Nutritional Risk*
6 or More *High Nutritional Risk*

Client Signature _____ **Date** _____

Based on assessment (check one):

No further action required _____
Refer to primary care physician _____
Refer to nutritionist _____
Other: _____ _____

Reviewed Nutrition Assessment with client: Yes _____ **No** _____

Practitioner Signature _____ **Date** _____

Apex Downriver Behavioral Health
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often** . . .
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid you might be physically hurt?
   Yes **No** If yes, enter 1 _____

2. Did a parent or other adult in the household **often or very often** . . .
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes **No** If yes, enter 1 _____

3. Did an adult or person at least 5 years older than you **ever** . . .
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes **No** If yes, enter 1 _____

4. Did you **often or very often** feel that . . .
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes **No** If yes, enter 1 _____

5. Did you **often or very often** feel that . . .
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes **No** If yes, enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes **No** If yes, enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit for at least a few minutes, or threatened with a gun or knife?
   Yes **No** If yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes **No** If yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes **No** If yes, enter 1 _____

10. Did a household member go to prison?
    Yes **No** If yes, enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.