Rethink Mental Illness.

www.rethink.org

My physical health.

A physical health check for people using mental health services.

Physical Health Check (PHC)

This PHC is designed to help people affected by mental illness identify (in conjunction with a health professional) any physical health needs they might have. The Action Plan at the end of the PHC offers the opportunity to address any identified needs. All information on this form will be treated as **CONFIDENTIAL**. One copy should be filed with the person's notes and a further copy should be provided for them to keep.

This PHC has been updated by Rethink Mental Illness[1] in response to the 2014/15 national CQUIN (Commissioning for Quality and Innovation) to improve physical health outcomes for people affected by mental illness.

Name:_____

Date of birth:_____

Date of completion:_____

Name of assessor:_____

Job role:_____

[1] The PHC was originally developed by Dr Michael Phelan, Linda Stradins, Dipti Amin, Anne Doyle, Rik Inglis (West London Mental Health Trust), Rachel Isadore (Hammersmith and Fulham Social Services) and Christine Hitrov (Central and North West London Mental Health Trust).

General health and lifestyle

As you go through these questions, please add anything that needs follow up to the 'Action Plan' on the last page

1.1 Do you have any diagnosed physical health conditions?
If **yes**, please give details: (include both minor and serious conditions)

If yes, are you receiving treatment for these? **Yes** ☐ **No** ☐
If **yes**, please give details:

List any conditions not currently receiving treatment:

1.2 Do you have a disability or impairment? **Yes** ☐ **No** ☐
If **yes**, please give details:

1.3 Have any of your immediate family or deceased relatives (parents, siblings) had any of the following conditions? (It is usual to specify under the age of 60 years)

Heart disease ☐	Stroke ☐	Cancer ☐	Diabetes ☐
Family history of any other illness / condition, please specify and give details:			

1.4 Please list all medications you are currently using.
(Include psychiatric and non-psychiatric medications, creams, inhalers, complementary treatments and any other remedies)
If you do not know the names of your medication, indicate this in the table below.

	Name of medication	Dose	Frequency	Date commenced
1				
2				
3				
4				
5				
6				

Do you have any problems with any of these medications (e.g. weight gain, disrupted sleep)? **Yes** ☐ **No** ☐
If **yes**, please give details:

Do you need information about any of the medications you are currently taking? **Yes** ☐ **No** ☐
If **yes**, please give details:

1.5 Do you think you eat a healthy diet? Yes ☐ No ☐

(**prompts**: regular meals, fruit and vegetables, number of takeaways)
Can you give examples of what you eat on a typical day?

1.6 Do you take part in any physical activity or exercise? Yes ☐ No ☐

(**prompts**: walking, cycling, gardening etc.)
If **yes**, what do you do and how often?

1.7 Do you smoke cigarettes or tobacco? Yes ☐ No ☐

If **yes**, how much do you smoke per day?

If **no**, have you smoked in the past? Yes ☐ No ☐

If **yes**, what date did you quit? Yes ☐ No ☐

1.8 Do you drink alcohol? Yes ☐ No ☐

If **yes**, how often have you had 6 or more units (female), or 8 or more (male), on a single occasion in the last year?

0	1	2	3	4
Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐

NB – one unit is half a pint of beer/lager/cider, a small glass of wine, one measure of spirits.

Are you aware of the recommended maximum units of alcohol per day? Yes ☐ No ☐

If **no**, would you like more information on this? Yes ☐ No ☐

1.9 Do you use recreational or non-prescription drugs (e.g. cannabis)? Yes ☐ No ☐

If **yes**, what do you use and how often do you use them?

1.10 Would you like information and support on any of the issues raised above:

- Improving your diet Yes ☐ No ☐
- Increasing physical activity Yes ☐ No ☐
- Stopping or cutting down smoking Yes ☐ No ☐
- Reducing alcohol intake Yes ☐ No ☐
- Stopping or reducing drug use Yes ☐ No ☐

1.11 Are you aware of the risks of sexually transmitted infection? Yes ☐ No ☐

If **no**, would you like more information on this? Yes ☐ No ☐

Would you like further information on any other sexual health issue?
(**prompts**: pregnancy, contraception, impotence etc.)

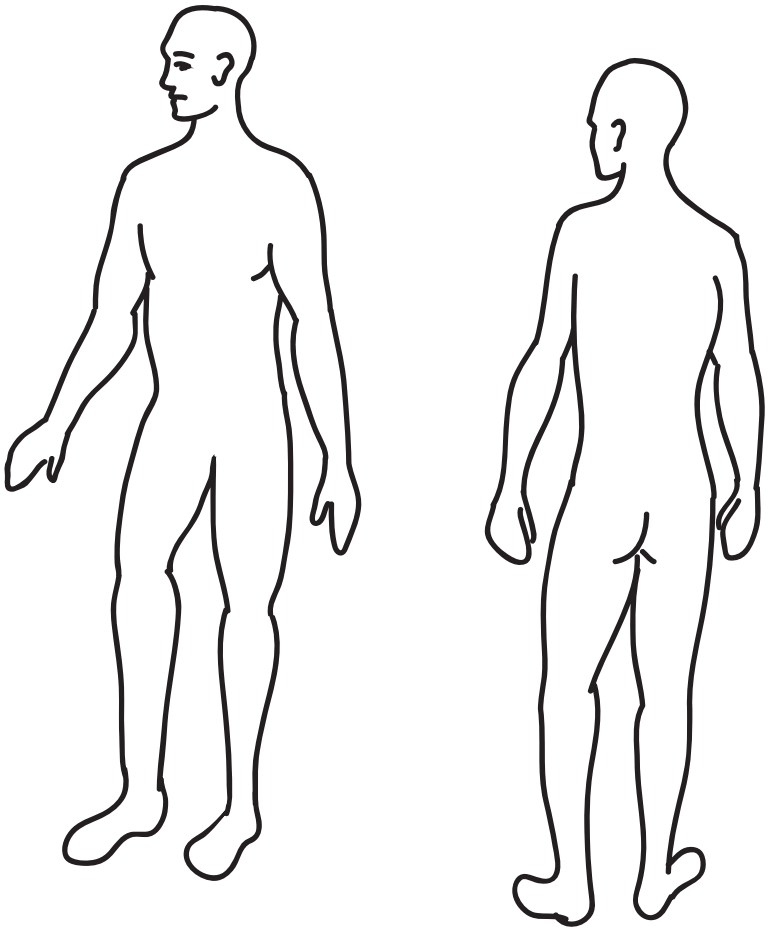
Symptoms checklist

This section is for you to describe any current physical symptoms you are experiencing. Please give as much detail as possible in this section.

2.1 In Table A below, tick any of these symptoms experienced.

	tick
Increased thirst	☐
Problems with urination	☐
Breathlessness	☐
Weight gain (unexpected)	☐
Weight loss (unexpected)	☐
Fits / blackouts	☐
Constipation	☐
Difficulties having sex	☐
Chest pain	☐
Difficulty sleeping	☐
Loss of feeling in feet	☐

Please give details:



2.2 On each body figure please use numbers to indicate any areas where you experience current or regular pain, discomfort or difficulties in your body.
Please include issues such as skin, dental, feet, ear problems or incontinence.

Place a number in each area of difficulty on the body and then use **Table B** to explain further details about it. For example, '1' placed over the chest area might indicate: **Problem** - chest pain, **Frequency** - when exercising, **Impact** - prevents me from exercising.

Table B
For other symptoms marked on body outline, note frequency and severity in the table below:

Number	Problem	Frequency	Impact
Example: 1	Chest pain	When exercising	Prevents me from exercising

Screening checks

This section should be used to highlight areas that may require investigation and alert you to the need for checks that may be overdue.

3.1 Are you registered with a GP? Yes ☐ No ☐

3.2 Are you registered with a dentist? Yes ☐ No ☐

3.2 General health checks

	Date / timing	Any other details:e.g. reason for visit / results of test
When did you last visit your GP or practice nurse?		
When did you last visit your dentist?		
When did you last have your eyes tested?		
When did you last have a blood test?		
When did you last have a screening for bowel cancer? (aged 60+)		
When did you last have a chlamydia screening? (25 and under)		

3.3 Gender specific checks

A: Checks for women

	Date /timing	Any other details:
When did you last have a cervical smear test?		
When did you last have a period?		
How often do you have your period?		
When did you last have a mammogram (for women aged 50+)?		

Do you check your breasts for lumps or other changes? Yes ☐ No ☐

If no, would you like more information on this? Yes ☐ No ☐

B: Checks for men

	Date /timing	Any other details:
How often do you examine your testicles?		

Are you aware of the increased risk of prostate problems in men aged 50+ ? Yes ☐ No ☐

If **no**, would you like more information on this? Yes ☐ No ☐

3.4 Please record the following information if possible:

Weight (Kg)		Waist circumference (cm)		Pulse		Blood Pressure	
Blood glucose		Lipids		BMI			

3.5 Any other issues

Are there any other issues we have not covered that you are concerned about? Yes ☐ No ☐

If **yes** please give details:

Your action plan

In this table indicate any health needs that have been identified and what actions are to be taken.

Name				Today's date	
Health need identified	What action is to be taken?	By whom?	When is the action to be taken?	Followed up when and by who?	Any other comments
`					

Final questions

Are you satisfied with what we have agreed?
If **no**, please give details:

Yes ☐ No ☐

Is there anything you are worried about as a result of this questionnaire?
If **yes**, please give details:

Yes ☐ No ☐

Do you need any extra support at this time to help you with the next step(s) we have identified?
If **yes**, please give details:

Yes ☐ No ☐

Notes

Rethink Mental Illness.

Leading the way to a better quality of life for everyone affected by severe mental illness.

For further information
Telephone 0300 5000 927
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www.rethink.org

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