

Client Name:

Client #:

DOB:

Diag. Code:

DOI:

Alaska Family Services, Behavioral Health Treatment Center
291 East Swanson Avenue * Wasilla, AK 99645
 Telephone: (907) 376-4000 * FAX: (907) 373-1135
HEALTH REVIEW AND RISK ASSESSMENTS

Health History:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any major illness or injury in the last 5 years
<input type="checkbox"/>	<input type="checkbox"/>	Any head or brain injuries, disorders or illnesses
<input type="checkbox"/>	<input type="checkbox"/>	Any seizures or epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses)
<input type="checkbox"/>	<input type="checkbox"/>	Ear disorders, loss of hearing or balance
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by:
	<input type="checkbox"/>	<input type="checkbox"/> diet
	<input type="checkbox"/>	<input type="checkbox"/> pills
	<input type="checkbox"/>	<input type="checkbox"/> insulin
<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders, e.g., severe depression
<input type="checkbox"/>	<input type="checkbox"/>	Loss of, or altered consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Problems with eating or sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe
<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease
<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Narcotic or habit forming drug use
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a personal physician or health clinic?

Date of last Physical Exam: _____

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1. Females:

Number of sexual partners in the last year (circle): 0-1 2-5 5-10 10+

Yes

No

Use protection when sexually active.

Past or present sexual relations with someone who has HIV, AIDS, or Hepatitis.

Sexual relations while under the influence of drugs or alcohol.

Traded sex for drugs or alcohol.

Had sex against your will.

Pregnant?

Gynecological Issues _____

Sexually transmitted diseases:

Herpes

Syphilis

Chlamydia

Genital Warts

Other: _____

2. Males:

Number of sexual partners in the last year (circle): 0-1 2-5 5-10 10+

Date of last prostate exam: _____

Yes

No

Use protection when sexually active

Past or present sexual relations with someone who has HIV, AIDS, or Hepatitis.

Sexual relations while under the influence of drugs or alcohol.

Traded sex for drugs or alcohol.

Had sex against your will.

Sexually transmitted diseases:

Herpes

Syphilis

Chlamydia

Genital Warts

Other: _____

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3. Tuberculosis Risk Assessment:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged, productive cough that produces discharge
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood
<input type="checkbox"/>	<input type="checkbox"/>	Fever and chills
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss
<input type="checkbox"/>	<input type="checkbox"/>	Feeling "run down" or easily tired
<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Exposed to a person with tuberculosis or TB
<input type="checkbox"/>	<input type="checkbox"/>	Immigrated or a refugee within the last 10 years
<input type="checkbox"/>	<input type="checkbox"/>	Moved to US from Mexico, Vietnam, China, India, Haiti, Korea, Philippines, or Polynesia
<input type="checkbox"/>	<input type="checkbox"/>	Date of last Tuberculosis test: _____
<input type="checkbox"/>	<input type="checkbox"/>	Test was positive
<input type="checkbox"/>	<input type="checkbox"/>	Completed treatment for Tuberculosis

Medical problems of biological parents you may have inherited, such as a tendency toward heart disease, diabetes, or cancer.

List all Medications:

<u>Name:</u>	<u>Dosage:</u>	<u>Frequency:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Allergies:
