Comprehensive Psychiatry Group, Inc.

PATIENT MEDICAL HISTORY & PHYSICAL SCREENING

Patient Name ___________________________ Gender __________ Date of Birth ____________

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

Allergies/Adverse Reactions ____

Primary Care Physician_______________________ Last Physical Exam __________________

Height ___________________Weight ________________________

Vaccinations: ❑ Smallpox ❑ DPT ❑ MMM ❑ MMM Booster ❑ Hepatitis B ❑ Tetanus (last dose)

NUTRITIONAL ASSESSMENT

Appetite ❑ Normal ❑ Poor Weight Change ❑ No ❑ Yes ____ lbs

Any special diet? ❑ No ❑ Yes _______________

Growth problems/eating disorder ❑ No ❑ Yes _________________

SURGERIES / HOSPITALIZATIONS

REASON	YEAR	AGE	REMARKS
1.			
2.			

FAMILY MEDICAL HISTORY

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

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System Review /Medical Conditions

	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	❑	❑			

- **= Triggers an immediate need for Physical Screening with PCP / Specialist**

REPRODUCTIVE HEALTH ❑ N/A

Age at Puberty _____ ❑ N/A Pregnancies _______ Menopause _____

Completed by: (Patient / Parent Name) ______________________________ Date ___________

____
Patient

Please complete the next page if patient is 18 years or younger

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CHILD / YOUTH PHYSICAL HEALTH ASSESSMENT

Please specify concerns about your child's functioning in any of the following areas

Specify Current or Past Concerns

❑ **motor** development ❑ NO ❑ YES ____________________

❑ **sensorimotor** functioning ❑ NO ❑ YES ____________________

❑ **speech** functioning ❑ NO ❑ YES ____________________

❑ **hearing** functioning ❑ NO ❑ YES ____________________

❑ **language** functioning ❑ NO ❑YES ____________________

❑ **visual** functioning ❑ NO ❑ YES ____________________

❑ **immunization** status ❑ NO ❑ YES ____________________

❑ **oral health** & hygiene ❑ NO ❑ YES ____________________

❑ 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
❑ oral health ❑ immunization status

❑ N/A to all of the above – no external referrals warranted

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))

❑ N/A