Patient Name
ID#
Or
Patient Label

SELF-REPORT MEDICAL QUESTIONAIRE

Intensive Outpatient Program (IOP) & Chemical Dependency Intensive Outpatient Program (CDIOP)

Name: ____

Name of Primary Care Physician: ______________________ **Last seen for physical:** __________

Physical Health Assessment

Do you CURRENTLY suffer from any of the following medical problems?

Food or Drug Allergies: ☐ I have **NO** known food or drug allergies

1. __________________ Reaction: ______________________
2. __________________ Reaction: ______________________
3. __________________ Reaction: ______________________

Musculoskeletal:
- ☐ None Known
- ☐ Arthritis
- ☐ Back pain or injury
- ☐ Other_______________

____

Neurological:
- ☐ None Known
- ☐ Seizures
- ☐ Weakness/paralysis
- ☐ History of stroke
- ☐ Traumatic Brain Injury
- ☐ Other_______________

____

Gastrointestinal:
- ☐ None Known
- ☐ Nausea/Vomiting
- ☐ Acid reflux/GERD
- ☐ Other_______________

____

Cardiovascular:
- ☐ None Known
- ☐ Chest pain/angina
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of heart attack
- ☐ Other _______________

Endocrine:
- ☐ None Known
- ☐ Diabetes (check one):
  - ☐ Controlled by medicine
  - ☐ Controlled by diet only
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Other_______________

____

Respiratory:
- ☐ None Known
- ☐ Asthma
- ☐ COPD
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Other: _____________

Bowel Patterns:
- ☐ None Known
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other_______________

____

Surgical History:
- ☐ None

____
____
____
____

Reproductive:
- ☐ None Known
- ☐ History of Sexually Transmitted Infections
- ☐ Pregnant
- ☐ Other_______________

____

Urinary:
- ☐ None Known
- ☐ Urinary Tract Infection
- ☐ Incontinence
- ☐ Other_______________
- ☐ Tuberculosis
- ☐ Hepatitis ____________
- ☐ Other_______________

Infection:
- ☐ None Known
- ☐ HIV

Immunizations:
- ☐ Up to date
- ☐ Unknown

Nose and Throat:
- ☐ None Known
- ☐ Sore throat
- ☐ Sinus problems
- ☐ Other_______________

Skin:
- ☐ None Known
- ☐ Eczema or rash
- ☐ Ulcers or lesions
- ☐ Discolorations
- ☐ Other_______________

____

Dental Assessment:
- ☐ None Known
- ☐ Braces/Dentures
- ☐ Broken/Missing teeth
- ☐ Other: ______________

Hearing Assessment:
- ☐ None Known
- ☐ Hearing impaired/Uses hearing aid device
- ☐ Deaf/Mute
- ☐ Other _______________

Vision Assessment:
- ☐ None Known
- ☐ Glasses/Contacts
- ☐ Legally blind
- ☐ Other: ______________

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Sleep:
□ None Known
□ Insomnia
□ Nightmares
□ Intermittent awakening
□ Early awakening
□ Other_______________

Nutritional Assessment

PLEASE CHECK ALL THAT APPLY: □ I have **NO** nutritional/dietary issues
□ Uncontrolled Diabetes
□ Gastric Bypass/Lap band in past 12 months
□ Pregnancy or Lactating
□ Diagnosed with an Eating Disorder
□ Unintentional weight loss/gain >10lbs in past 3 mos
□ Decrease in appetite, due to ______________________________________
□ Increase in appetite, due to ______________________________________

□ Special Diet
□ Heart disease
□ Immune deficiency disorder
□ Other: _________________________
□ Restricting intake, binge eating, and or inducing vomiting

Pain Assessment

1. Do you have **CHRONIC** pain? □ Yes □ No ***If no, skip to question #9**
2. Impact of **chronic** pain on daily activities & functioning: □ None □ Somewhat limiting □ Very limiting
3. Location of **chronic** pain: ____
4. Frequency: □ Continuous □ Intermittent
5. Type of Pain:
   □ Ache
   □ Burning
   □ Sharp
   □ Throbbing
   □ Shooting
6. Aggravating factors: □ Sitting □ Standing □ Walking □ Lying down □ Other _____________________________
7. Are you under the care of a primary care physician or pain management physician to manage your **chronic** pain?
   □ Yes □ No
   If yes, Name of Physician: ____
8. Do you need/want a referral for your **chronic** pain? □ Yes □ No

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9. Do you have **CURRENT** pain? □ Yes □ No ***If no, skip to additional comments/signature section below**

10. Impact of **current** pain on daily activities & functioning: □ None □ Somewhat limiting □ Very limiting

11. Location of **current** pain: ____

12. Frequency: □ Continuous □ Intermittent

13. Type of Pain:
- □ Ache
- □ Burning
- □ Sharp
- □ Throbbing
- □ Shooting

14. Aggravating factors: □ Sitting □ Standing □ Walking □ Lying down □ Other ____________________________

15. Current Pain level: Choose a face that best describes your current pain.

16. Pain relief interventions used: □ Deep breathing/relaxation techniques □ Medication _______________________
□ Massage □Sleep □ Other ____

Additional Comments for the Outpatient Nurse (if needed):
____
____
____
____
____

Patient Signature:____ **Date:** _________ **Time:** _________

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SELF-REPORT MEDICAL QUESTIONAIRE

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THE FOLLOWING IS TO BE COMPLETED BY STAFF ONLY

NURSING ASSESSMENT SUMMARY

Nutritional Consult

❒ **Nutritional consult is NOT indicated**

❒ **Nutritional consult IS indicated**

- ❒ **Date and time request was made:** ____/____/______ _____:_____ am pm
- ❒ **Patient refused nutritional consult**

Medical Referrals

❒ **No referrals indicated**

❒ **Refer patient to Primary Care Physician for**____

Interventions/Initial Plan

❒ **1:1 with Psychiatrist/Psychiatric Nurse Practitioner for medication management**

❒ **History and Physical exam**

❒ **3 hr group therapy Mon-Fri**

❒ **Random drug and ETOH screenings (to be completed at least once weekly for CD-IOP pts)**

❒ **Other:** ____

RN Signature:____ Date: ___________ Time: _____

PHYSICIAN REVIEW

This review is based on the information provided by the patient and reviewed by nursing staff. It is the opinion of the signing physician that the patient:

❒ Needs further physical evaluation beyond the physical required by the program
❒ Other: ____

Comments ____

Physician Signature:_____________________________________ **Date:** ______________ **Time:** ___________

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THE FOLLOWING IS TO BE COMPLETED BY STAFF ONLY

AUDIT-C ALCOHOL USE ASSESSMENT

1. **How often do you have a drink containing alcohol? (Select one response.)**

❒Never **(0)** ❒Monthly or less **(1)** ❒ 2-4 times a month **(2)** ❒ 2-3 times a week **(3)** ❒ 4 or more times a week **(4)** **Score_____**

2. How many drinks containing alcohol do you have on a typical day when you are drinking? (Select one response.)

❒ 1 or 2 **(0)** ❒ 3 or 4 **(1)** ❒ 5 or 6 **(2)** ❒ 7 to 9 **(3)** ❒ 10 or more **(4)** **Score_____**

3. How often do you have 6 or more drinks on one occasion? (Select one response.)

❒Never **(0)** ❒ Less than monthly **(1)** ❒ Monthly **(2)** ❒ Weekly **(3)** ❒ Daily or almost daily **(4)**
Score_____

Total Score:______	**Male**	❒ **No/Low Risk (0-3)**	❒ **Moderate Risk (4+)**
	Female	❒ **No/Low Risk (0-2)**	❒ **Moderate Risk (3+)**

Scoring: The AUDIT-C is scored on a scale of 0-12. Each question above is scored from 0 to 4 (the scores are in parentheses next to each response). In men, a score of 4 or more is considered positive for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive. However, if all of the points are from the first question and the second and third question score 0, you should review the patient's alcohol intake over the past few months to confirm accuracy. © World Health Organization