MEDICAL ASSESSMENT FORM

This form must be completed by a physician. The cost of the health questionnaire is the responsibility of the client. This information is being collected under the authority of the Alberta Alcohol and Drug Abuse Act.

Date: _____ **Patient Name**: _____

DOB: _____ Occupation: _____

Address: _____

Medical History_____

_____

_____

Psych History_____

_____

_____

Surgical History_____

_____

_____

Medications_____

Allergies (*please specify)* ____Anakit_____

Dietary Requirements _____

DRUG HISTORY

	Name of Drug	**Date of last use**
Alcohol	_____	_____
Cannabis	_____	_____
Cocaine	_____	_____
Opiates	_____	_____
Amphetamines (Including crystal meth)	_____	_____
Benzodiazepines	_____	_____
Other	_____	_____

PHYSICAL EXAM

HEIGHT_____ **WEIGHT**_____ **BP**_____ **PULSE**_____

ENT_____ CHEST_____

CVS_____ **ABD**_____

NEURO_____ **M/SK**_____

SKIN_____ **ENDO**_____

[redacted]

HISTORY	YES	NO	Comments explain YES responses
Drug & Alcohol Abuse or addiction			
Mental Health Disorders			
Eating Disorder			
Sleep Disorder			
Nervous Disorders			
Urinary tract disorders			
Hepatic Disorders (Hepatitis, HBV, HCV)			
Circulatory system Disorder			
Reproductive System Disorder			
Respiratory System Disorder			
Gastrointestinal Disorder			
Pancreatic Disorder (diabetes)			
Pain- Chronic, Acute			
Suicidal tendencies			
Attempted Suicide			
Seizures			
STD's including HIV, AIDS			
Liver Function Test			
Other health related problems			
Blood Pressure _____ /_____			
Blood Sugar _____			
Weight Loss ____lbs time span ___			
Calcium Level:			
Zinc Level:			
Magnesium Level:			
B12 Level:			
Vitamin D Level:			
Fatigue			
Night Sweats			
Fever			
Blood in Sputum			
Cough lasting longer than 2 weeks			
Exposure to Tuberculosis			
Chest X-Ray results			
Birth or travel to place with high incidence of Tuberculosis			
Previous treatment for Tuberculosis			
Poor general health status			
Chronic medical conditions			
Possible risk factor for progression of disease			
Further screening required			
Further assessment required			
Other risk factors for infection			
Pregnancy if yes # of months			
Disabilities			
Eyesight problems			
Dental problems			

Client is medically and physically able to participate in an intensive group-counselling program.

Physician Name: _____ Physician Signature: _____Date: _____

Thank you for completing the attached form. Please fax to: 403-242-3915