***Greater Malden Behavioral Health, Inc.***

**HEALTH SCREEN**

|  |  |
| --- | --- |
| **Name:** Click here to enter text. | **Date:** Click here to enter text. |
| **Date of Birth:** Click here to enter text. | **MIS Number:** Click here to enter text. |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL HEALTH** | | | | | | | | |
| Do you have high blood pressure? | | | | | Yes | | | No |
| Do you have a heart condition (i.e. chest pains, heart murmur, or stroke)? | | | | | Yes | | | No |
| Do you have a thyroid condition? | | | | | Yes | | | No |
| Are you experiencing pain? | | | | | Yes | | | No |
| Do you have Diabetes Mellitus? | | | | | Yes | | | No |
| Do you have asthma, breathing or lung problems? | | | | | Yes | | | No |
| Do you have Allergies? | | | | | Yes | | | No |
| Do you have cancer (other than skin cancer)? | | | | | Yes | | | No |
| Do you have seizures, seizure medication, neurological problems or dizziness? | | | | | Yes | | | No |
| Do you have a history of high cholesterol? | | | | | Yes | | | No |
| Family history or coronary heart disease? | | | | | Yes | | | No |
| Do you smoke tobacco products? | | | | | Yes | | | No |
| Do you consume alcohol? | | | | | Yes | | | No |
| Do you do drugs?  If so, what kind? Click here to enter text. | | | | | Yes | | | No |
| Is stress from daily living an issue in your life? | | | | | Yes | | | No |
| Have you been hospitalized for a medical condition within the last five years? | | | | | Yes | | | No |
| If so, for What? | | Where? | | | | | | |
| Click here to enter text. | | Click here to enter text. | | | | | | |
| When was your last physical examination?Click here to enter text. | | | | | | | | |
| Do you have a physician you see on a regular basis? Yes  No | | | | | | | | |
| Name of Physician: | | | | | | | | Click here to enter text. |
| Physician Location Click here to enter text. | | | | | | | | |
| Would you like PBA to assist you in finding a physician and scheduling an appointment? | | | | | | | Yes  No | |
| Are you prescribed medications for medical conditions? | | | | | | | Yes  No | |
| **Name of Medication** | **Dosage** | | **Frequency**  *(How Many Times a Day)* | | | | **Purpose of Medication** | |
| 1.Click here to enter text. | Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | |
| 2.Click here to enter text. | Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | |
| 3.Click here to enter text. | Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | |
| 4.Click here to enter text. | Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. | |
| **Fitness** | | | | | | | | |
| Do you exercise on a regular basis?  Yes  No | | | | | | | | |
| How often do you exercise?Click here to enter text. Do you find exercise helpful?  Yes  No | | | | | | | | |
| What type of exercise do you participate in? Click here to enter text. | | | | | | | | |
| Do you take supplements?  Yes  No *(Please list below)* | | | | | | | | |
| **Name of Supplement** | | | | **Purpose of Supplement** | | | | |
| Click here to enter text. | | | | Click here to enter text. | | | | |
| Click here to enter text. | | | | Click here to enter text. | | | | |
| How do you manage stress? Click here to enter text. | | | | | | | | |
| Have you tried acupuncture treatment?  Yes  No | | | | | | *Interested?*  Yes  No | | |
| Have you tried meditation?  Yes  No | | | | | | *Interested?*  Yes  No | | |
| Have you tried yoga?  Yes  No | | | | | | *Interested?*  Yes  No | | |
| Have you tried colon cleansing?  Yes  No | | | | | | *Interested?*  Yes  No | | |
| **DIET/NUTRITION** | | | | | | | | |
| How often do you eat meat? Click here to enter text. | | | | | | | | |
| Do you eat cold cuts or lunch meat? Click here to enter text. | | | | | | | | |
| How often do you eat fruit? Click here to enter text. | | | | | | | | |
| How often do you eat vegetables?Click here to enter text. What vegetables do you eat? Click here to enter text. | | | | | | | | |
| How often do you eat fish? Click here to enter text.  Do you eat foods/meats fried?  Yes  No Or baked foods/meat?  Yes [ ] No | | | | | | | | |
| Are you interested in weight loss?  Yes  No | | | | | | | | |
| Are you interested in seeing a nutritionist?  Yes  No | | | | | | | | |
| **HOUSING** | | | | | | | | |
| Do you have adequate housing?  Yes  No  *Need assistance in getting adequate housing?*  Yes  No | | | | | | | | |
| Are you homeless?  Yes  No Need assistance in getting housing*?*  Yes  No | | | | | | | | |
| Are you dealing with eviction or foreclosure?  Yes  No | | | | | | | | |
| **EMPLOYMENT** | | | | | | | | |
| Are you employed?  Yes  No  *Need assistance with employment or obtaining a higher income?*  Yes  No | | | | | | | | |

Do you have any other Health and/or Medical concerns?  Yes  No

*(Please describe):*Click here to enter text.