PATIENT NAME: _____GENDER: Female DATE OF ADMISSION: _____
HOME ADDRESS: _____
PHONE_____ AGE _____DOB_____
CERTIFYING PHYSICIAN: _____ PHONE_____

A. ALCOHOL HISTORY:

FREQUENCY: _____LAST USE:_____

B. DRUG HISTORY:

SUBSTANCE: _____FREQUENCY:_____LAST USE:_____
SUBSTANCE: _____FREQUENCY:_____LAST USE:_____
SUBSTANCE: _____FREQUENCY:_____LAST USE:_____

D PSYCHIATRIC HISTORY:

DIAGNOSIS: _____

_____

IS PATIENT PSYCHOTIC? Y/N IS PATIENT SUICIDAL? Y/N

HISTORY OF SUICIDE ATTEMPT? **Y/N** DATES:_____

IS PATIENT SELF-MUTILATING? **Y/N** FREQUENCY: _____LAST INCIDENT: _____

ORIENTED TO TIME, PLACE AND PERSON? **Y/N**

E. EATING DISORDER HISTORY: Y/N – please send recent blood work results if applicable.

DIAGNOSIS: _____

CURRENT STATUS: _____

F. GENERAL HEALTH HISTORY:

ALLERGIES: **Y/N** TYPE: _____

CONVULSIONS: **Y/N** DATE: _____TREATMENT:_____

DT': **Y/N** DATE: _____TREATMENT:_____

HISTORY OF DIABETES: **Y/N** TREATMENT: _____

CARDIOPULMONARY: _____

GASTROINTESTINAL: _____

GENITOURINARY: _____

OTHER HEALTH ISSUES: _____

DATE OF LAST MENSES: _____

HEIGHT _____ WEIGHT_____

OTHER _____

_____

G. CURRENT PHYSICAL EXAMINATION:

HEART: _____

LUNGS: _____

ABDOMEN: _____

EXTREMITIES: _____

NEUROLOGIC: _____

DENTAL PROBLEMS: _____

OTHER: _____

**ANY VISABLE SIGNS OF HEADLICE: _____ OR BED BUGS/BITES: _____
If, so what is the course of treatment? _____

CLIENT IS FREE FROM SCABIES: Y/N

ANY RESTRICTIONS OR LIMITATIONS TO EXERCISE EITHER INDEPENDENTLY OR USING EXERCISE EQUIPMENT:

SMOKER: **Y/N If Yes – DAILY USE? _____**

H. AXIS I _____ _____ _____
AXIS II _____ _____ _____
AXIS III_____ _____ _____
AXIS IV_____ _____ _____
AXIS V _____ _____ _____

I. CURRENT MEDICATIONS:
Attach Medical Discharge Summary

J. LABORATORY WORKUP:
PPD **OR** DATE: _____RESULTS:_____
CHEST X-RAY: DATE: _____RESULTS:_____

PLEASE PROVIDE A 30 DAY REFILL or SCRIPT On ALL CURRENT PRESCRIPTION FOR THE PATIENT TO BRING TO HALEY HOUSE.
PLEASE INCLUDE ALL AVAILABLE MEDICAL RECORDS. THANK YOU!

This is to certify that I have examined_____and find her to be free of communicable diseases and not in need of nursing care. She is non-psychotic and is not bedfast and is reasonably well oriented.
I certify that the above information is accurate and that I enclose all medical records in my possession on this patient.

_____ _____
DATE **PHYSICIAN'S SIGNATURE**

Please fax form to: 908-362-5450