HISTORY & PHYSICAL EXAM-ALL questions must be addressed, if it does not apply, please state N/A.

1. Full Name:	2. Address:	
3. Date of Birth:	4. Height:	5. Weight:
6. Primary Diagnoses:	7. Secondary Diagnoses:	

8. Current medical treatments or therapies:

9. Physical Disabilities:	10. Sensory Functioning/Aides:

11. Mobility Devices Used: ☐Walker ☐Cane ☐Wheelchair ☐ None ☐Other_____

12. Cognitive Status: *(memory skills, orientation, behavioral problems, safety habits)*

13. Is client free from communicable diseases: ☐ YES ☐NO
If a communicable disease is present, what precautions must be taken to prevent the spread of disease in a group setting?

14. Medical information pertinent to diagnoses & treatment in case of emergency *(call 911, call PCP, etc..):*

15. Physician Orders: (list any additional medications on reverse side or attach list)

List Medications:	Dosage:	Schedule:

16. Individual may have PRN while at 2nd Home Adult Day Center:
☐ Tylenol Dose:_____ Freq:_____
☐ Ibuprofen Dose:_____ Freq:_____
☐ Antacid Dose:_____ Freq:_____

17. Allergies:	18. Dietary Restrictions, if any:

I have thoroughly examined the above-mentioned client and find that he/she is not in need of hospital care, does not require bed rest during the day, therefore is able to participate in an adult day program. Date of exam required to be within 3 months of enrollment date.

19. Physician/Physician Assistant/CRNP Name: _____ (Please check one) MD/DO__PA-C___CRNP____

Address: City: State: Zip:

Phone: Fax:

Physician/Physician Assistant/CRNP Signature: _____20. DATE OF EXAM: _____

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