

Physical Form from Applicants MEDICAL Treatment Team

Applicant's Name _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

I. Medical Profile

A. Applicants Diagnosis (DSM-IV-R)

Axis III:

II. General Medical History

A. Please indicate whether the applicant currently has or has had any of the following medical problems.

We require that all medical records/ lab results relating to conditions for which the applicant is currently being treated and those that require ongoing treatment.

Dizziness, Fainting, Seizures	N	Y	Blood Pressure	N	Y	Diabetes	N	Y
Migraines	N	Y	High Cholesterol	N	Y	Cancer	N	Y
Head Injury	N	Y	Thyroid	N	Y	Anemia/Other Blood Disorder	N	Y
Stroke	N	Y	Neck/Back Injury	N	Y	Kidney Disease	N	Y
Asthma/Lung Disease	N	Y	Arthritis	N	Y	Major Surgeries	N	Y
Heart Disease/Murmur	N	Y	Fractures	N	Y	Other	N	Y
High Risk for TB	N	Y	please provide proof of two-step TB test					

If yes, please explain: _____

Allergies and/or adverse reactions to medications:

B. Does the applicant use any medical aids/devices such as glasses, CPAP, hearing aids

C. Is this applicant capable of participating in a life skills program which includes physical work outside? *(if not, explain)*

D. Any physical limitations/restrictions?

E. Does applicant need further medical follow up?

III. Current Medications

Medication	Dose	Time Taken	Reason Prescribed

IV. Physician Signature (Attests to Medical Profile): _____

Printed Name _____ Date _____

Address: _____ Phone _____

City/State/ZIP _____ Email _____