Physical Examination Requirements
Nebraska Urban Indian Health Coalition, Inc.
Residential Treatment Program

Name: _____ Age: _____ Gender: M____ F____

Address: _____ City: _____ Zip: _____

Physician: _____

Medication Allergies: _____ _____

Other Allergies: _____

PHYSICAL FINDINGS

Height: _____ Weight _____
Blood Pressure: _____ Pulse: _____
Urinalysis: _____
Hemoglobin/Hct:_____
Total Cholesterol:_____
Blood Glucose:_____
Vision Screening Report:
OD:_____ OS:_____ With Glasses:_____
Oral Health Report:_____
Any Vision and Dental Problems must be addressed prior to Treatment

Immunizations given during today's visit:

DPT:____TD:____ Polio:____ MMR:____ Varicella:____

PPD: ____PPD Result Date: _____ Result: Pos. Neg.

Hepatitis Screen: Hep A:____ Hep B: ____ Hep C:____

Past Hep Dx ____ Treated ____ Untreated ____If Pos, must be treated.

Social History

	Yes	No	Amt
Tobacco			
ETOH			
Street Drugs			

Recent injury? Yes No Type:_____

Date of injury:_____

Temporary Handicap Certification			
Cast	Brace(s)	Ace Wrap(s)	Splints

Medical	Normal	Abnormal	Abnormal Findings
Musculoskeletal			
Neck			
Spine			
Shoulder/arm			
Wrist/hand			
Elbow/forearm			
Hip/thigh			
Knee			
Leg/ankle			
Foot			
Evidence of Scoliosis		Yes	No
Evidence of Hernia		Yes	No
Stigmata of Marfan's Syndrome		Yes	No

Systemic Diseases _____

Mode of treatment_____

Diabetes Screen: _____No Diabetes_____Diabetes_____
Blood Glucose:_____Glucometer Used_____Owned_____
Diabetes Uncontrolled_____Diabetes controlled_____
Mode of treatment_____
General Limitations_____

Required medication on a daily or episodic routine:_____
_____
_____

Significant findings/Chronic Health Problems/Mental Health:
_____
_____

Please check classification

- Regular — Client may participate in regular alcohol/drug treatment activities without undo risk or harm
- Adapted — Client has a condition which might pose a risk in the participation of regular alcohol/drug treatment
- Exempt — Client has a condition which prohibits them from participation in alcohol/drug treatment

Your signature below indicates completion of physical exam and review of health history

Signed: _____ Date: _____

Examining Medical Provider Signature Required