1. Immunizations up to date: □ No □ Yes 
   ○ If no, explain: ____________________________  
   If no- refer for PCP

2. Do you currently have an untreated illness/communicable/infectious disease: □ No □ Yes 
   ○ If yes, explain: ____________________________  
   If yes- refer for PCP

3. Do you have a history of disability: □ No □ Yes 
   ○ If yes, explain: ____________________________

4. Problems with: □ Hearing □ Vision □ Other: ____________________________  
   If marked, do you need accommodations: □ No □ Yes 
   ○ If yes, explain: ____________________________

5. Do you have any difficulties with sleep: □ No □ Yes 
   ○ If yes, explain: ____________________________

ALLERGY

6. If answered ‘Yes’ to allergies (on Health Assessment) and have medication allergies, specify name(s) and type of reaction: ____________________________

PAIN SCREENING

7. If answered ‘Yes’ to pain (on Health Assessment):
   • How frequently does pain interfere with your life activities: 
     □ Never □ Rarely □ Less than 1x/wk □ 1x/wk □ 2-3x/wk □ Daily
   • Does your pain affect any of the following: 
     □ Sleep □ Concentration □ Physical Activity □ Emotions □ Appetite □ Social Relationships
   • How long have you had the pain: 
     □ 0-1 month □ 2-12 mos. □ 13 mos-5 years □ 5+ years
   • Do you have untreated/undertreated pain: □ No □ Yes 
     If yes- refer for Pain
NUTRITION SCREENING

8. Do you have food allergies/sensitivities:  ☐ No ☐ Yes  If yes- refer for Nutrition
   ○ If yes, specify name(s) and type of reaction: _________________________________

9. Have you gained or lost more than 10 pounds in the last 3 months:  ☐ No ☐ Yes  If yes- refer for Nutrition*
   ○ If yes, specify reasons why*: ___________________________________________
   *Only refer if reasons specified indicate clinical need

10. Do you have any untreated/undertreated dental problems:  ☐ No ☐ Yes  If yes- refer for Dental

11. Have you had an increase in food intake and/or appetite:  ☐ No ☐ Yes  If yes- refer for Nutrition

12. Have you had a decrease in food intake and/or appetite:  ☐ No ☐ Yes  If yes- refer for Nutrition

13. Do you have eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or induced vomiting:  ☐ No ☐ Yes  If yes- refer for Nutrition
   ○ If yes, specify: _________________________________________________________

Client signature (age 12 or older) ________________________________  ________________
Date

Parent/Guardian signature (required if client is under 18) ________________________________  ________________
Date

For Staff Use Only- Referrals provided:

From Health Risk Assessment:
☐ No PCP  ☐ Past due physical  ☐ OBGYN  ☐ Smoking cessation

From Health Risk Assessment Addendum:
☐ Immunization/Untreated Illness  ☐ Pain  ☐ Nutrition  ☐ Dental

Staff signature ________________________________  ________________
Date