Counseling & Wellness CENTER

# Medical Screen FOR PCP

**Your patient has elected to opt out from the medical screening process provided by CWC and has chosen to be screened by you to rule out or identify any medical condition that may be contributing to their psychological symptoms. Please complete this form in its entirety and fax to 304.428.3719 Attention: Medical Coordinator**

I, _____ (PCP Name), hereby certify the information given is, to the best of my knowledge, true and correct. I further agree to take full responsibility for the initial medical screening for _____ (Patient Name). By signing, I have completed the full medical evaluation of my patient and determined they are appropriate for outpatient services by ruling out any medical condition that may contribute to their psychological symptoms services. In addition, I have assessed and determined they are not a threat to themselves or anyone else (no suicidal or homicidal ideations/attempts) and do not need more intensive services (e.g. Intensive Outpatient Services or Inpatient services). I understand if Counseling & Wellness Center determines the need for more intensive service are required upon initial intake, then my patient will be sent back to me for reevaluation and reassessment to make a referral for more appropriate services.

_____ _____

***PCP SIGNATURE*** ***DATE***

***X***

***X*** _____ _____

***PATIENT SIGNATURE*** ***DATE***

# MEDICAL HISTORY AND SCREENING FORM

The purpose of medical screening is to identify potential health problems which may be contributing to the presenting psychological symptoms. It is best practice to address medical problems separately from psychological intervention. In keeping with these standards and to promote continuity of care Counseling & Wellness Center will not provide counseling services until a medical screening has been appropriately conducted to rule out any medical conditions as a contributing factor for psychological symptoms. Please have your **Primary Care Physician** complete the information below prior to being scheduled.

## General Information

Name _____

Address _____

Contact phone numbers _____

Birth date _____

**Family Physician and/or Primary Health Care Provider:**

Doctor/Other _____ Phone _____

Address _____ City _____

## Past Medical History

**Check those questions to which you answer yes (leave the others blank) & comment below. Have you ever had or do you have any of the following health problems?**

- ☐ Substance Abuse:
  - o Alcohol
  - o Marijuana
  - o Other drugs
- ☐ Bleeding tendency
- ☐ Breast disease
- ☐ Cancer
  - o Breast
  - o Uterine
  - o Other
- ☐ Psychiatry
  - o Depression
  - o Anxiety
  - o Bipolar
  - o Eating disorder
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Cardiac
  - o Heart murmur
  - o Heart attack
  - o High blood pressure
- ☐ Hepatitis
- ☐ Glaucoma
- ☐ Dental disease
- ☐ Neuro
  - o Migraine
  - o Stroke
  - o Seizure
  - o Other _____
- ☐ GI
  - o Jaundice
  - o Liver disease
  - o Gallbladder disease
  - o Gastritis/Ulcer disease
  - o Acid reflux
  - o Hemorrhoids
  - o Other_____
- ☐ Kidney
  - o Kidney infection
  - o Bladder infection
  - o Kidney stones
- ☐ Thyroid disorder
- ☐ Varicose veins
- ☐ Seizure disorder
- ☐ Lung
  - o Sleep apnea
  - o Asthma

- o Chronic Obstructive Pulmonary Disease
- o Tuberculosis
- o Seasonal allergies
- o Other
- ☐ Environmental allergies
- ☐ Blood clots
- ☐ Serious trauma
- ☐ Sexually transmitted infection
- ☐ Other _____

**Comments:** _____

_____

_____

_____

**SYMPTOMS**

**Are you currently having or have you recently had any of the following symptoms? Check those questions to which you answer yes (leave the others blank).**

- ☐ Fevers
- ☐ Night sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue
- ☐ Headaches
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Eye pain
- ☐ Ear pain
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Hoarse voice
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Chest pain
- ☐ Palpitations/irregular heartbeat
- ☐ Swelling of extremities
- ☐ Shortness of breath
- ☐ Lightheadedness
- ☐ Change in appetite
- ☐ Abdominal pain
  - o Nausea
  - o Vomiting
  - o Diarrhea
- ☐ Rectal pain
  - o Change in bowel habits
  - o Blood in stool
  - o Black stool
- ☐ Muscle, bone or joint pain
- ☐ Leg cramps
- ☐ Skin color changes
- ☐ Persistent bruising
- ☐ Inability to sleep flat
- ☐ Change in size/color of mole
- ☐ Numbness of extremities
- ☐ Muscle weakness
- ☐ Tremor
- ☐ Urinary symptoms
  - o Blood in urine
  - o More frequent urination
  - o Incontinence/loss of urine
  - o Pain
- ☐ Sexual dysfunction
- ☐ Mood changes
- ☐ Difficulty sleeping

_____

**Comments:** _____

**SURGERIES:**

Type of surgery and specific date or your age at surgery: _____

_____

_____

**HOSPITALIZATIONS:**

List hospitalizations, including dates of and reasons for hospitalization: _____

_____

_____

**MEDICATIONS:**

List any prescription medications (with dosage and frequency of use) you are now taking: _____

_____

_____

List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use) you are now taking: _____

_____

_____

**ALLERGIES:**

List any drug or medical materials (latex) allergies and reaction: _____

_____

_____

## Family History

**Indicate illnesses in blood relative (i.e. parents, grandparents, siblings) - Check those questions to which you answer yes (leave the others blank).**

- ☐ Substance Abuse:
  - o Alcohol
  - o Marijuana
  - o Drugs
- ☐ Anemia
- ☐ Bleeding or clotting abnormality
- ☐ Breast disease
- ☐ Cancer
  - o Prostate
  - o Skin
  - o Colon
  - o Lung
  - o Breast cancer
  - o Other_____
- ☐ Diabetes
- ☐ Heart disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Mental illness
- ☐ Suicide
  - o Sibling
  - o Parents
  - o Grandparents
- ☐ Migraines/headaches
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Arthritis
  - o Rheumatoid
  - o Osteoarthritis
- ☐ Connective tissue disorder
  - o Lupus

**Health and Lifestyle**

Do you smoke?

☐ Yes ☐ No

If you smoke, how many per day? _____ Age started _____

Are you concerned about your own or someone else's alcohol abuse? ☐Yes ☐No

Have you ever felt you should cut down on your drinking? ☐Yes ☐No

Have people annoyed you by criticizing your drinking? ☐Yes ☐No

Have you ever felt bad or guilty about your drinking? ☐Yes ☐No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? ☐Yes ☐ No

Do you often having the feeling of being overwhelmed or depressed? ☐ Yes ☐No

Do you exercise? ☐Yes ☐No

If yes, type of exercise: _____

If yes, frequency of exercise _____

**Gynecologic History**

Do you have a period every month? ☐Yes ☐No

Number of days of flow: _____

Menstrual cramps: ☐Mild ☐Moderate ☐Severe ☐None

Date of last PAP smear: _____ Last PAP smear result: _____

Have you ever had an abnormal PAP smears? ☐Yes ☐No

If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear:

_____

Number of pregnancies: _____

Are you presently trying to become pregnant or will be trying soon? ☐Yes ☐No

Gynecologic symptoms: **Check those questions to which you answer yes (leave the others blank).**

- ☐ Abnormal menstrual bleeding
- ☐ Missed periods
- ☐ Night sweats
- ☐ Hot flashes
- ☐ Vaginal dryness
- ☐ History of prescription hormone use
- ☐ Mood changes associated with period
- ☐ Insomnia

_____ _____

Physician Signature Date