



Pre-Admission History and Physical

NAME _____ DOB _____

CC: _____

HPI: _____

PH:Hosp/Surg _____

Meds: _____

Immunizations Date: Hep A _____ Hep B _____ MMR _____ DTaP _____
TB/PPD _____ Date Admin _____ Lot # _____ Date Read _____ Result _____

Signature _____

Adv. Directives _____ Tobacco _____ ETOH _____ Illicit Drugs _____

REVIEW OF SYSTEMS:

Constitutional: Weight Loss/Gain _____ Fever _____ Fatigue _____ Pain _____ Cachexia _____

Eyes: Watery/Purulent Discharge _____ Redness _____ Blurred/Double Vision _____

ENT: Hearing Loss _____ Ringing _____ Pain in Ear/Sinus _____ Drainage _____ Dizzy _____

Mouth Sores _____ Difficulty Swallowing _____ Dental Problems/Enamel Damage _____

Cardio: Chest Pain _____ Palpitation _____ SOB on Exercise _____ Edema _____

HTN _____ Faintness _____ Hypotension _____

Resp: Cough, Chronic/Acute _____ SOB _____ Wheezing _____ Sputum _____ Asthma _____

Bronchitis _____ Pneumonia _____

GI: Appetite Loss _____ Change in BM _____ N/V _____ Diarrhea _____ Constipation _____

Abdominal Pain _____ Heart Burn _____ Blood in Stool _____

GU: Freq. _____ Dysuria _____ Hematuria _____ Nocturia _____ Incontinence _____

Sexual Difficulty _____ Freq/Irreg. Periods _____ Impotence _____ Amenorrhea _____

MS: Joint Pain/Stiffness/Swelling _____ Weakness _____ Cramps _____ Back Pain _____

Arthritis _____ Decreased Muscle Mass _____

Skin/Breast: Rash _____ Itching _____ Color Change _____ Dry _____ Breast Pain/Lumps/Discharge _____

Varicose Veins _____

Neuro: HA _____ Lightheaded _____ Dizziness _____ Numbness/Tingling _____ Tremors _____

Memory Loss _____ Confusion _____

Psych: Anxiety _____ Nervousness _____ Depression _____ Mood _____ Insomnia _____

Endocrine: Hormone/Thyroid _____ DM _____ Heat/Cold Intolerance _____

Dry Skin _____ Thirsty _____

Hema/Lymph: Cuts Slow to Heal _____ Bleeds or Bruises Easily _____ Anemia _____

Enlarged Glands _____

Allergies: Drug _____ Chronic _____ Seasonal _____



PHYSICAL EXAM: *Please indicate WNL or ABN where appropriate. If abnormal, please describe in detail in assessment below. Orthostatic vital signs, weight in gown, and measured height are required.

Const: Orthostatic VS: Sit BP: _____ Sit Pulse _____ Stand. BP: _____ Stand. Pulse _____
Resp _____ HT _____ WT (in gown) _____

Gen: Development _____ Nutrition _____ Grooming _____

Eyes: Conj/Lids _____ PERRLA _____ Optic Discs/Retina/Vessels _____ Visual Acuity: R eye _____ L eye _____

Ears: Ext Ears/Nose _____ Hearing _____ Acuity _____ Canal/TM's _____

Nose: Nasal Mucosa/Sept/Turb _____ Oropharynx _____

Mouth: Lips/Teeth/Gums _____ Parotiditis/Parotid Enlargement _____ Dental Caries _____ Pain _____
Loose/Broken/Missing Teeth _____ Dental Plaque/Oral Lesions _____ Last Dental Exam _____

Throat: Thyroid _____ Trachea _____

Chest: Inspection (Symmet/No Nipple D/C) _____ Palpation Breast and Axillae _____

Resp: Percuss _____ Palpation _____ Resp Effort _____ Clear/Equal _____

CV: Palpation _____ Pedal Pulse _____ Carotid Pulse _____
Femoral Pulse _____ Edema/Varicosities _____ Aorta _____ Acrocyanosis _____

EKG: NSR _____ Arrhythmia _____ QTC/QT Prolongation _____

GI: Hep-Spl Meg _____ Hernia _____ Masses/Tender _____ Neg Guaiac _____
Anus/Peri/Rect/Hemorrh/Rectal Mass/Tone _____

GU: M Penis _____ DRE of Prostate _____ Scrotum _____
F Ureth _____ EX _____ Adnexa _____ Ext Gen/Vag _____ Bladder _____
Uterus _____

Lymph: LN (Neck/Axillae/Groin/Other) _____

MS: Gait _____ Digits/Nails/Extremities _____ Head/Neck _____ Spine/Rib/Pelvis _____
Misalign/Assymet/Defect/Mass/Effusion) _____ Muscle Strength/Tone _____
ROM/Pain/Contracture/Crep. _____ Stability/Discolor/Sublux/Laxity _____

Skin: Rash/Lesion/Ulcer _____ Induration/SQ Nodules/Tightening _____

Neuro: Cranial Nerves _____ Sens _____ DTR/Babinski _____

Psych: Judgment/Insight _____ Recent/Remote Memory _____ O x 3 _____
Mood _____ Suicidal Thoughts _____ Homicidal Thoughts _____

ASSESSMENT / PLAN:

Based on my physical exam, reviewed laboratory data, and EKG, I declare this patient medically stable, free of contagious diseases, and suitable for residential treatment at Castlewood Treatment Center. I understand that Castlewood Treatment Center is an ambulatory, non-medical, mental health facility without 24 hour direct nursing care.

Signature: _____ Date: _____