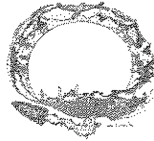
Tanana Chiefs Conference



Behavioral Health
Medical History & Physical Screening

Name ____________ Date _____________

Old Minto Family Recovery Camp is an Alcohol and Drug treatment program operated by Tanana Chiefs Conference in Fairbanks, Alaska. The program setting is isolated, rural, and accessible only by small plane and boat and treatment is expected to take five weeks. A condition of admission is that clients be able to fully participate in all activities, which include hauling water, cutting and lifting wood, Subsistence Activities, etc. All clients are required to obtain a health screening to ensure that there are no medical conditions or severe withdrawal potential that would interfere with treatment and leave the client at risk for complications.

HEALTH CARE PROVIDERS: Please fill out this form to the best of your knowledge. Thank You.

Please check if the client has ever had any of the following and explain "Yes" answers on the lines below:

Yes	No		Yes	No	
☐	☐	Major Illnesses	☐	☐	Severe fatigue after little activity
☐	☐	Allergies (food, drug, other)	☐	☐	Unusual thirst or hunger
☐	☐	Abnormal blood pressure	☐	☐	Hepatitis (A, B, or C)
☐	☐	Asthma	☐	☐	Appetite/ability to each changes
☐	☐	Liver disease	☐	☐	Blurred vision or difficulty seeing
☐	☐	Diabetes	☐	☐	Buzzing or ringing in ears
☐	☐	Back Injury	☐	☐	Seizures
☐	☐	Major injuries/surgeries	☐	☐	Frequent colds or coughs
☐	☐	Tired all the time	☐	☐	Recent changes in weight
☐	☐	Swollen feet or ankles	☐	☐	Problems with sleep or rest
☐	☐	Head Injury	☐	☐	Bleeding gums or teeth problems
☐	☐	Severe Headache or Migraines	☐	☐	Shortness of breath with exercise
☐	☐	Heart problems in self or family	☐	☐	Venereal Disease
☐	☐	Unusual Swelling in limbs	☐	☐	Cancer
☐	☐	Skin problems	☐	☐	Kidney problems
☐	☐	Constipation or diarrhea	☐	☐	Aching joints or muscles
☐	☐	Any problem with urination	☐	☐	Blood in stool or urine
☐	☐	Hernia	☐	☐	Other: ___________________

Please explain any 'Yes' responses:

____

____

____

____

(Please use back of page if needed)

Please check current immunizations:

☐ Flu Shot ☐ Hepatitis B Shot ☐ Pneumonia ☐ Tetanus Shot ☐ Other _____________

Does the client have family members or a close relationship with anyone who has active:

Tuberculosis __No __Yes Mental Illness __No __Yes If yes, please explain:

____

Has the client been screened for Tuberculosis? __No __Yes Last test date:________ Results:______________

If not screened within last six months, give PPD. If there is a previous history of PPD conversion, is the client symptom free?____

Please list hospitalizations or operations or Emergency room visits within the past three years: ____________

____

____

Is the client currently under a doctor's care? __No __Yes, Why? ______________________________
Doctors name, address and phone number required

Name: ____ Phone: ________________

Address: ______________________________________

____

Date of last physical exam:______________________________ Doctor:__________________________

Date of last dental visit:________________________________ Dentist:__________________________

Date of last vision exam:________________________________ Optician:_________________________

Is the client currently taking any **prescription medications**? __No __Yes→ Please list below:
NOTE: Opiate based medications are not allowed at camp. Please indicate if any of the above are opiate based and if there is an alternative that can be prescribed for a 35 day residential treatment stay.

Medication	Dosage	For what Condition	45-day Supply?	
____________________	__________	____________________	☐ Yes	☐ No
____________________	__________	____________________	☐ Yes	☐ No
____________________	__________	____________________	☐ Yes	☐ No
____________________	__________	____________________	☐ Yes	☐ No

Is any of the above medication mind-altering? Explain: ______________________________________

Is the client currently taking any **over-the-counter products**? __No __Yes→ Please list product and what for:

____

Does the client currently have any special dietary requirements? __No __Yes → If yes describe below:

____

High Risk and Priority Assessments

Has the client ever been tested for HIV? __No __Yes. Would client like to be tested for HIV? __No __Yes

Has the client ever been tested for Hepatitis (A, B, or C)? __No __Yes. Would client like to be tested? __No __Yes

Is client an injection drug user? __No __Yes → Drug?__________ Last Used ______ With Whom?__________

____

FEMALES ONLY - Date of last period ________ Is client pregnant? __ No __Yes __Don't Know __Think so
____Any unusual vaginal discharge____ Regular periods: Y N
____Excessive menstrual bleeding: ____ Last PAP: ______________
Do you use Birth Control Y N Type of Birth Control used:_______________ Last Pregnancy__________
On Hormone Therapy Y N

Is client currently having thoughts of: Suicide __No __Yes Homicide __No __Yes
Does the client have a history of attempted suicide or violent behavior toward self or others? Explain: __________

____

Please rate clients risk for harm to: self? ☐ High ☐ Medium ☐ Low
Please rate clients risk for harm to: others? ☐ High ☐ Medium ☐ Low

Is the client currently experiencing signs and symptoms of withdrawal – please check the following:
☐ None ☐ Nausea & Vomiting ☐ Tremor ☐ Sweats ☐ Tactile Disturbances ☐ Anxiety

☐ Agitation ☐ Auditory Disturbances ☐ Headache ☐ Orientation ☐ Visual Disturbances

History of withdrawal problems: ____

____

____

NOTE: As an optional part of treatment patients may take vitamin supplements for physical detoxification, including high doses of B vitamins. Would use of vitamins conflict with any of the patients medical conditions or medications? __No __Yes

Please comments on any concerns regarding client's ability to fully participate in all treatment activities.

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Based on findings of Medical Evaluation, client ☐Is recommended for Old Minto Family Recovery Camp.
☐Is not recommended for Old Minto Family Recovery Camp.

______________________ ______________ ____________
Health Provider's Name Phone# Date