Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Program# _____ Client Name: _____

Counsellor:_____ Date:_____

HEALTH SCREENING

A. Acute Medical Problems

Are there acute medical complications that may require referral to emergency/hospital for immediate medical assessment?

☐ Yes _____

☐ No

MEDICAL PROBLEMS THAT MAY REQUIRE MEDICAL ASSESSMENT

B. Medical History

When did you last see a physician? Who is your physician?

Are you currently in any type of treatment or counselling for emotional or mental health problems?
Is there a threat of harm to self or others?

Have you had any hospitalizations in the last year? For what reasons?

List all current medications (dosage).

C. Health Screening

Check all indicated and note concerns:

☐ unmanaged diabetes

☐ history of seizures/epilepsy

☐ cancer

☐ eating disorders (bulimia, anorexia, under/over eating)

☐ heart disease

☐ blood pressure problems

☐ liver disease (hepatitis-cirrhosis)

☐ kidney disease

☐ jaundice

☐ menstrual/menopausal difficulties

☐ possible pregnancy

☐ pancreatitis

☐ physical or sexual abuse

☐ emotional/verbal abuse

☐ recent untreated injuries

☐ risk of infectious diseases ☐ _____

☐ _____

☐ Sexually Transmitted Diseases (syphilis, gonorrhea, chlamydia, herpes)

☐ lice/scabies

☐ stomach problems (ulcers, gastritis)

☐ tuberculosis

☐ head injury

☐ other

Clinical Notes/Referrals Needed: