PACIFIC NORTHWEST
ADULT & TEEN
CHALLENGE

Medical History

Program Entry

-Confidential-

COMPLETE THIS FORM AND RETURN TO:

PNW Adult & Teen Challenge Regional Office
Intake Coordinator
6902 SE Lake Road – Suite 300
Milwaukie, OR 97267
Phone: (503)765-5252
Fax: (971)254-9892
Intake@teenchallengepnw.com

PACIFIC NORTHWEST
ADULT & TEEN CHALLENGE
PHYSICIANS REPORT

Please read carefully the following instructions.

1. The first two pages concern the Physicians Report. The first page identifies the tests that must be conducted by a Physician and the lab results sent in to **Pacific Northwest Adult & Teen Challenge Regional Office 6902 SE Lake Rd Suite 300, Milwaukie, OR 97267** or faxed to **(971) 254-9892.**

2. The physical Exam is to rule out contagious diseases or significant mental or physical impairment – similar to a sports physical – ***(use Doctor's forms);***

3. The specific tests to be conducted are listed below:

    - Tuberculosis test: **PPD** or chest x-ray or other tests as recommended by doctor.
    - Genital exam – ***if indicated*** for sexual transmitted diseases;
    - HIV test;
    - Hepatitis Panel – Complete (includes A, B and C screening lab test)

4. If the applicant is taking a particular medication while in the Teen Challenge program, the attending physician should have sufficient information to verify it and state the prescribed medication and dosage on page 2. ***This is a must*** or you may not be allowed to take the medication.

5. Non-prescription Items – Students are permitted to bring non-prescription items into the program or receive them from outside the program (aspirin, etc.), if, and only if, they are enclosed in the manufacturers original package and the wrapping seal is unbroken – ***NO EXCEPTIONS***.

6. The Medical History is to be filled out by the applicant and returned to the address below.

The applicant's signature below authorizes the tests listed above to be completed and the results and information sent to Pacific Northwest Adult & Teen Challenge Regional Office 6902 SE Lake Rd Suite 300, Milwaukie, OR 97267.

Applicant's Name (print): _____

Applicant's Signature: _____ Date: _____

Physician's Report (continued)

Upon examination, the patient's general physical health was found to be:

☐ Good ☐ Average ☐ Poor

The patient is experiencing a medical condition that restricts their participation in physical labor.

☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

_____

Physician's Authorization of Medication

List any medication prescribed for the patient by you or another physician. Please indicate if any of these prescriptions are habit forming to your knowledge.

Medication	Prescribed For	Habit Forming
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Physician's Name (print): _____

Phone Number: _____ Fax Number: _____

Address: _____

Physician's Signature: _____ Date: _____

Please return this and all test results and information to: Pacific Northwest Adult & Teen Challenge Regional Office – 6902 SE Lake Rd, Suite 300, Portland OR 97267 Fax (971) 254-9892.

PACIFIC NORTHWEST ADULT & TEEN CHALLENGE MEDICAL REPORT

Applicants Name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Height: _____ Weight: _____

Married: ☐ Yes ☐ No How long? _____ Nationality: _____

Blood Type: _____

Current physician: _____ Phone: _____

Pacific Northwest Adult & Teen Challenge is committed to helping students become physically, mentally and spiritually whole. We are not, however, a medical program. We will endeavor to assist you in securing whatever medical help we can while you are in the program. If you become ill or need medical attention once you are in the program we will assist in connecting you with a medical facility. You are responsible for any fees that accrue in connection with your visit to of treatment from any medical facility. We do not financially assist students in meeting their medical bills.

Explain in the space below any provisions you have to cover medical expenses while enrolled in Teen Challenge?

_____

_____

_____

Health Insurance: ☐ Yes ☐ No Insurance Company: _____

Policy Number: _____ Does your policy recognize recovery services? ☐ Yes ☐ No

Do you collect disability payments? ☐ Yes ☐ No

Emergency Contact Information

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to applicant: _____

Personal Medical History

Are you currently being treated by a physician for an illness, injury or medical symptom? ☐ Yes ☐ No

If so please provide the name of the physician: _____

Address: _____ Phone: _____

Describe any illness, injury or symptoms:

Are you currently receiving therapy for any of the circumstances described above? ☐ Yes ☐ No

If Yes, please explain.

Are you experiencing or have you experienced an injury or illness that affects your ability to participate in?

Manual Work Experience ☐ Yes ☐ No

Exercise Programs ☐ Yes ☐ No

Recreational Activities ☐ Yes ☐ No

If yes to any of the above, please explain.

Please list any food allergies

Are you allergic to bee stings? ☐ Yes ☐ No Do you need medication if stung? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

Please identify all medications you are allergic to in the space below.

Check if you have:

☐ Hay Fever	☐ Diabetes	☐ Asthma	☐ Seizures	☐ Epilepsy
☐ Convulsions	☐ Blackouts	☐ Arthritis	☐ Dizziness	☐ Chronic Fatigue
☐ Chronic Backaches	☐ Sinus Trouble	☐ Migraines	☐ Blurred Vision	☐ Double Vision
☐ Loss of Sight	☐ Loss of Hearing	☐ Ear Infections	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Gonorrhea	☐ Syphilis	☐ Herpes	☐ Aids	☐ Chlamydia

Are you currently taking any medications for any of the conditions mentioned above? ☐ Yes ☐ No

If so, please identify the medications (by name) that you are taking, dosage and frequency below:

Check if you have: ☐ Heart Trouble ☐ Chronic Cough ☐ Hemorrhoids ☐ Ulcer's ☐ Jaundice ☐ Heart Burn ☐ Acid Reflex ☐ Black Stool ☐ Kidney Stones ☐ Hepatitis

Are you currently taking any medications for any of the conditions mentioned above? ☐ Yes ☐ No

If so, please identify the medications (by name) that you are taking, dosage and frequency below:

Are you experiencing:

☐ Poor Appetite	☐ Nausea	☐ Vomiting	☐ Vomiting Blood
☐ Frequent Indigestion	☐ Frequent Diarrhea	☐ Frequent Constipation	
☐ Intestinal Parasites	☐ Persistent Weight Gain	☐ Persistent Weight Loss	
☐ Coughing up Blood	☐ Blood in Urine	☐ Frequent Urination	
☐ Bladder infections	☐ Problems Urinating	☐ Severe Itching	
☐ Problems Sleeping	☐ Depression	☐ Anxiety	

Are you currently taking any medications for any of the conditions mentioned above? ☐ Yes ☐ No

If so, please identify the medications (by name) that you are taking, dosage and frequency:

Have you had:

☐ Measles	☐ Chicken Pox	☐ Scarlet Fever	☐ Whooping Cough
☐ Mumps	☐ Small Pox	☐ Typhoid Fever	☐ Diphtheria
☐ Tuberculosis	☐ Pneumonia	☐ Cancer	☐ Anemia
☐ Nervous Breakdown	☐ Head Injury		

Are you currently taking any medications for any of the conditions mentioned above? ☐ Yes ☐ No

If so, please identify the medications (by name) that you are taking, dosage and frequency:

If you have had a head injury where you lost consciousness or were admitted to a hospital for evaluation, please explain the nature of your injury and if experience and difficulties as a result of the injury in the space below. (memory loss, lack of concentration, headaches, vision problems etc.)

Describe any illness or developmental condition that you experienced as a child?

Describe any serious injuries or broken bones:

Identify any major surgeries you have experienced starting with the most recent:

Do you have any special diet restrictions or requirements? ☐ Yes ☐ No Please explain:

Date of last eye exam: _____ Results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you required to wear prescription glasses? ☐ Yes ☐ No Do you presently own a pair? ☐ Yes ☐ No

Date of your last dental exam: _____ Condition of your teeth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please describe any problems that you are experiencing with your teeth.

How many cups of caffeinated drinks (coffee, tea, pop, energy drinks) do you have per day? _____ Cups

How many packs of cigarettes to you smoke per day? _____ Do you use chewing tobacco? ☐ Yes ☐ No

Have you ever received mental health treatment not related to drug or alcohol use? ☐ Yes ☐ No

Name of Clinic _____ Date: _____

Reason for Mental Health Treatment: _____

Name of Clinic: _____ Date: _____

Reason for Mental Health Treatment: _____

Name of Clinic: _____ Date: _____

Reason for Mental Health Treatment: _____

Name of Clinic: _____ Date: _____

Reason for Mental Health Treatment: _____

Would you be willing to authorize release of information from the above clinics to Teen Challenge? ☐ Yes ☐ No

For Women Only

Age when you first experienced a period: _____ Days between: _____ Length of period: _____

Do you have normal menstrual cycles? ☐ Yes ☐ No If no, please explain in the space below.

Do you experience a ☐ Heavy ☐ Medium ☐ Light flow?

Do you experience any bleeding between periods? ☐ Yes ☐ No Please explain in the space below.

When was your last pelvic exam? Date: _____ Were there any adverse findings? ☐ Yes ☐ No

Please explain:

Do you think you are pregnant at this time? ☐ Yes ☐ No

Number of full term Pregnancies: _____

Have you experienced any miscarriages? ☐ Yes ☐ No Have you had any abortions? ☐ Yes ☐ No

Please explain any complications.

Have you experienced menopause? ☐ Yes ☐ No

Please explain any complications below.

Have you experienced an eating disorder such as anorexia or bulimia? ☐ Yes ☐ No

Please describe in detail including any treatment you have received for this in the space below.

Substance Abuse and Treatment History

Indicate below the alcohol, drug and medical programs you have attended.

Date Admitted and Discharged	Program/Facility	Reason for Leaving

Please explain types of treatment and counseling received.

Please use the chart below to describe your use of alcohol and drugs.

When answering the question of **"How Often Taken",** use **O** for Once, **ST** for Several Times, **R** for Regularly and **C** for continuous usage.

ALL DRUG TYPES USED: (include street drugs, alcohol, illegal prescriptions, over the counter & other drugs.)	CURRENTLY USING		PRESCRIBED BY A PHYSICIAN		AGE WHEN FIRST USED	AGE WHEN LAST USED	HOW OFTEN TAKEN	CHECK USUAL METHOD OF ADMINISTRATION				
	YES	NO	YES	NO				Oral	Smoke	Snort	IM	IV
Alcohol	☐	☐	☐	☐				☐	☐	☐	☐	☐
Amphetamines/speed (Uppers Benzedrine, Dexedrine, etc.)	☐	☐	☐	☐				☐	☐	☐	☐	☐
Anti-depressants	☐	☐	☐	☐				☐	☐	☐	☐	☐
Barbiturates/downers	☐	☐	☐	☐				☐	☐	☐	☐	☐
Chew – Tobacco	☐	☐	☐	☐				☐	☐	☐	☐	☐
Cocaine/crank	☐	☐	☐	☐				☐	☐	☐	☐	☐
Codeine	☐	☐	☐	☐				☐	☐	☐	☐	☐
Darvon	☐	☐	☐	☐				☐	☐	☐	☐	☐
Diladud	☐	☐	☐	☐				☐	☐	☐	☐	☐
Hallucinogens (LSD, Acid, Mescaline, etc.)	☐	☐	☐	☐				☐	☐	☐	☐	☐
Heroin	☐	☐	☐	☐				☐	☐	☐	☐	☐
Inhalants (Glue, Paint, Gasoline, etc.)	☐	☐	☐	☐				☐	☐	☐	☐	☐
Marijuana/hashish	☐	☐	☐	☐				☐	☐	☐	☐	☐
Meth												
Methadone – non-legal	☐	☐	☐	☐				☐	☐	☐	☐	☐
Opiates (Percodan, Opium, Morphine)	☐	☐	☐	☐				☐	☐	☐	☐	☐
PCP (Angel Dust, etc.)	☐	☐	☐	☐				☐	☐	☐	☐	☐
Ritalin	☐	☐	☐	☐				☐	☐	☐	☐	☐
Tobacco – smoking	☐	☐	☐	☐				☐	☐	☐	☐	☐
Tranquilizers	☐	☐	☐	☐				☐	☐	☐	☐	☐
Valium, Librium	☐	☐	☐	☐				☐	☐	☐	☐	☐
Other (specify):												

The undersigned fully acknowledges that the information provided herein is accurate and true to the best of his or her knowledge. Any false or incomplete information may cause and result in disqualification from admittance or dismissal from the program.

Applicant

Date

IF THIS APPLICATION FORM HAS BEEN COMPLETED OR FILLED OUT BY ANYONE, OTHER THAN STUDENT APPLICANT, PLEASE PROVIDE FOLLOWING:

Name of individual filling out the form

Date

Relationship to Applicant