



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
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Chronic Backaches | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Migraines | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Loss of Sight | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Aids | <input type="checkbox"/> 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:
- | | | | | |
|--|--|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ulcer's | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Acid Reflex | <input type="checkbox"/> Black Stool | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> 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:
- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Vomiting Blood |
| <input type="checkbox"/> Frequent Indigestion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Frequent Constipation | |
| <input type="checkbox"/> Intestinal Parasites | <input type="checkbox"/> Persistent Weight Gain | <input type="checkbox"/> Persistent Weight Loss | |
| <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Frequent Urination | |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> Severe Itching | |
| <input type="checkbox"/> Problems Sleeping | <input type="checkbox"/> Depression | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines/speed (Uppers Bensedrine, Dexedrine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-depressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Barbiturates/downers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chew – Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/crank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Darvon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diladud	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens (LSD, Acid, Mescaline, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants (Glue, Paint, Gasoline, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meth												
Methadone – non- legal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates (Percodan, Opium, Morphine)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP (Angel Dust, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ritalin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco – smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Valium, Librium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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

CONFIDENTIAL