



OUTPATIENT INITIAL ASSESSMENT

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

ACCOUNT NUMBER: _____

DATE OF SERVICE: _____

Preferred Name/ Nickname: _____ Preferred contact number: _____

Emergency contact Name/ Number: _____ Relationship: _____

For Staff use only:

Wt: _____ kg Ht: _____ in BP: _____ Pulse: _____ RR: _____ SaO2: _____ Temp: _____

Health History: Do you have any of the following conditions:

☐ Connective Tissue Problems	☐ Lung Problems	☐ Diabetes
☐ Musculoskeletal Problems	☐ Liver Problems	☐ Stroke/TIA
☐ Implantable Devices	☐ Bowel Problems	☐ Infection
☐ Elevated Blood Pressure	☐ Kidney Problems	☐ Pacemaker
☐ Heart problems	☐ Urinary/bladder	☐ Cochlear Implants

Allergies: ☐ Yes ☐ No Medications: _____

Other: _____ Reaction: _____

Surgeries: _____

Menstrual history: ☐ NA ☐ Last period _____ ☐ Post-menopausal

Do you have pain? ☐ No ☐ Yes If yes, where is it: _____

Please rate your pain: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What are you currently doing/taking to relieve your pain: _____

Tuberculosis screen: please check all that apply: ☐ Active TB/ Current treatment ☐ Cough >3 weeks

☐ Bloody sputum ☐ Night sweats ☐ Weight loss ☐ Recent exposure to TB (within 24 months)

Social History:

Alcohol use: ☐ No ☐ Yes How many drinks per week: _____

Recreational drug use: ☐ No ☐ Yes Describe: _____

Do you have an advance directive? ☐ No ☐ Yes Copy on chart? ☐ No ☐ Yes

History of falls: ☐ No ☐ Yes Describe: _____

Do you live alone: ☐ No ☐ Yes If no, with whom: _____

Do you use any assistive devices: ☐ No If yes, ☐ walker ☐ cane ☐ wheel chair ☐ other _____

Do you need assistance with Activities of daily living? (e.g. bathing, shopping, eating, etc.) ☐ No ☐ Yes

If yes, please describe: _____

Out of concern for your well- being:

Do you live in an environment where you feel threatened or afraid: ☐ No ☐ Yes

Do you feel like hurting yourself or others: ☐ No ☐ Yes

Assessment form completed by: _____

PATIENT SIGNATURE _____

PRINTED NAME _____

DATE/TIME _____

RN SIGNATURE _____

PRINTED NAME OR CORPORATE ID _____

DATE/TIME _____



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