Fort Frances Tribal Area
HEALTH SERVICES

MINO AYAA TA WIN HEALING CENTRE
MEDICAL ASSESSMENT

Instructions: To be completed by a Physician, Nurse Practitioner or Nursing Station. Note: This client is registered to attend a residential alcohol and drug treatment program. The treatment is an intensive, 28-day program that promotes wholistic wellness, trauma and addiction issues.

Clients Name:	Date of Birth: (d/m/yr)
Health Card #:	Blood Pressure:
Height:	Weight:
Vision:	Hearing:
Chest:	Heart:
Abdomen:	Extremities:
Allergies:	
Present Health Problems: Past Health Problems:	

Current Medication:

Medication:	Dosage:	Frequency:

*Additional medications can be attached.

Are you aware of any difficulties that we should consider in treatment? Please provide details. Example: extreme anxiety, suicidal thoughts, depression, etc.

General:

☐ YES	☐ NO	Is a special diet needed? If yes, please explain:
☐ YES	☐ NO	Is this client free of communicable diseases? If no, please explain:
☐ YES	☐ NO	Is this client able to participate in physical recreation? With some restrictions? Explain:
☐ YES	☐ NO	Does this client have any mobility restrictions? If yes, please explain:

SYMPTOM SCREENING FOR TUBERCULOSIS (TB)

☐ YES	☐ NO	Have you ever had TB Disease?
☐ YES	☐ NO	Have you ever had a TB skin test? If yes, please include date and result:
Do you have any of the following symptoms:		
☐ YES	☐ NO	New or worsening cough? If yes, how long?
☐ YES	☐ NO	Productive cough?
☐ YES	☐ NO	Fever? If yes, how long?
☐ YES	☐ NO	Chills? If yes, how long?
☐ YES	☐ NO	Fatigue? If yes, how long?
☐ YES	☐ NO	Night sweats? If yes, how long?
☐ YES	☐ NO	Weight loss? If yes, how long?
☐ YES	☐ NO	Loss of appetite? If yes, how long?
☐ YES	☐ NO	Are you taking any antibiotics now?

Additional comments:

Physician/Nurse Practitioner (print): _____	Telephone: _____
Signature: _____	Date: _____

Please return this copy to the client OR contact: Intake Worker- intake@fftahs.com
Phone: 807-271-0194 Fax: 807-274-3211