

Grafton Bio-Psychosocial Evaluation

Physical Examination

Client Name: _____	Date of Assessment: _____
Date of Birth: _____	Social Security Number: _____

Physical Examination And History
List any drugs or forms of anesthesia to which this individual has had untoward reactions or for some reason are specifically contraindicated for this individual:
Any Known Allergies? _____
History of Presenting Illness: _____
Past Medical History: _____
Past Surgical History: _____

Immunizations
Hepatitis Bx _____ DTaP x _____ Hib x _____ IPV x _____ MMR x _____
Varicella x _____ Pneumococcal x _____ PPD <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Meningococcal _____
Influenza: _____ Any adverse reactions to influenza vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No
Any adverse reactions to another vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, which vaccine? _____

Females Only
Age at Menarche: _____ Average duration of menstruation: _____
Length between cycles: _____ Has client ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has client ever had an abortion or miscarriage? <input type="checkbox"/> Yes <input type="checkbox"/> No

Sexual History
Is client presently sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No
When sexually active, does client use protection? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does client have a history of sexually transmitted diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is client aware of the "high risk" diseases associated with sexual activity; such as STD, HIV, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many sex partners has client had in the past six months? _____
Total number of sex partners? _____
Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Unable to Answer <input type="checkbox"/> Refused to Answer

Grafton Bio-Psychosocial Evaluation

Physical Examination

Review of Systems			
<p>General:</p> <input type="checkbox"/> Recent Weight Change <input type="checkbox"/> Weakness	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever	<p>Skin:</p> <input type="checkbox"/> Rashes <input type="checkbox"/> Lumps <input type="checkbox"/> Itching <input type="checkbox"/> Color Changes <input type="checkbox"/> Changes in Hair/Nails <input type="checkbox"/> Hypo/Hyperpigmentation	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Sores <input type="checkbox"/> Dryness <input type="checkbox"/> Burning <input type="checkbox"/> Edema <input type="checkbox"/> Tattoos <input type="checkbox"/> Scars
<p>Ears:</p> <input type="checkbox"/> External Ear Pain <input type="checkbox"/> Hearing Difficulties <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Tube Placement <input type="checkbox"/> Excess Cerumen	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Tinnitus <input type="checkbox"/> Earaches <input type="checkbox"/> Discharge <input type="checkbox"/> Vertigo	<p>Eyes:</p> <input type="checkbox"/> Pain <input type="checkbox"/> Excessive Lacrimation <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Specks <input type="checkbox"/> Retinal Detachment	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Redness <input type="checkbox"/> Diplopia <input type="checkbox"/> Spots <input type="checkbox"/> Flashing Lights <input type="checkbox"/> Glaucoma
<p>Head:</p> <input type="checkbox"/> Headache <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Dizziness	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Head Injury <input type="checkbox"/> Hx of Lice <input type="checkbox"/> Alopecia	<p>Nose and Sinuses:</p> <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Hx of Seasonal Allergies <input type="checkbox"/> Hx of Allergic Rhinitis	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Discharge <input type="checkbox"/> Itching <input type="checkbox"/> Hx. of Epistaxis <input type="checkbox"/> Sinus Problems
<p>Mouth and Throat:</p> <input type="checkbox"/> Lip Abnormalities <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Tonsils Removed <input type="checkbox"/> Sore Tongue	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Cavities <input type="checkbox"/> Hoarse	<p>Neck:</p> <input type="checkbox"/> Lumps <input type="checkbox"/> Painful Glands <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> Excessive Sweating	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Goiter <input type="checkbox"/> Thyroid Issues
<p>Breasts:</p> <input type="checkbox"/> Pain/Discomfort <input type="checkbox"/> Nipple Discharge	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Lumps	<p>Hematologic:</p> <input type="checkbox"/> Past Transfusions When? _____	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Easily Bruised
<p>Respiratory:</p> <input type="checkbox"/> Sputum(Color: _____) <input type="checkbox"/> Wheezing <input type="checkbox"/> Bronchitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hemoptysis	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Cough <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pleurisy <input type="checkbox"/> Dyspnea	<p>Cardiac:</p> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Chest Pain <input type="checkbox"/> EKG _____	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> HBP <input type="checkbox"/> Palpitations <input type="checkbox"/> Orthopnea
<p>Musculoskeletal:</p> <input type="checkbox"/> Muscle or Joint Pain <input type="checkbox"/> Weakness <input type="checkbox"/> Scoliosis <input type="checkbox"/> Limited Motion/Activity <input type="checkbox"/> Tenderness	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Backache <input type="checkbox"/> Redness	<p>Neurologic:</p> <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Tingling Sensation <input type="checkbox"/> Involuntary Movements <input type="checkbox"/> Hx of Dystonic Reaction <input type="checkbox"/> Abnormal Gait	<p><input type="checkbox"/> No Hx.</p> <input type="checkbox"/> Syncope <input type="checkbox"/> Blackouts <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremors

Grafton Bio-Psychosocial Evaluation

Physical Examination

Objective Continued	
<p>Ears:</p> <p>Pain upon palpation of tragus, pinna or mastoids? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Whisper test + in both ears, intact CN VIII? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>TM's Clear B/L? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weber test WNL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rinne test WNL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p>Mouth:</p> <p>Lip lesions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tongue texture/color WNL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Missing teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Uvula intact and midline? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Caries noted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pharynx clear? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tonsils enlarged? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tonsils removed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Intact gag reflex, intact CN IX and X? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tongue protrusion, intact CN XII? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Eyes:</p> <p>PERRLA? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>EOM intact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red reflex B/L? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fundi normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Increased intraocular pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ptosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Corneal scar? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lid lag? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>CN II intact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>CN III, IV & VI intact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p>Neck:</p> <p>Thyroid enlargement or nodules? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cervical adenopathy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Full range of motion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Trachea midline? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Supple? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Intact CN XI via shoulder shrug? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>
<p>CVS:</p> <p>RRR? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Murmurs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rubs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gallops? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lifts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thrills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radial pulse B/L and symmetric? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Brachial pulse B/L and symmetric? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dorsalis Pedis pulse B/L and symmetric? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Conjunctiva <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p>Lungs:</p> <p>Wheezing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rales? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rhonchi? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>CTA B/L? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Intact tactile fremitus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Intact respiratory expansion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>
<p>Back:</p> <p>Pain upon palpation of the para-vertebral muscles? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Full ROM? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Scoliosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kyphosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lordosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p>Notes: _____</p> <p>_____</p> <p>_____</p>

Grafton Bio-Psychosocial Evaluation

Physical Examination

Objective Continued	
<p>Male GU:</p> <p>Urethral discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Testicular enlargement or lesions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Variocoele? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tanner Stage? _____</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p>Abdomen:</p> <p>Scars or lesions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>NABS? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Organomegaly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Point tenderness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rebound tenderness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain upon palpitation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Evidence of hernia (ventral, inguinal, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>
<p>Female:</p> <p>Genitalia – no lesions/growths? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cervix closed – no lesions/growths? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vagina no d/c; no lesions/normal rugae? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Uterus Midline anteverted posterior? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>BiManual no CMT? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>No ovarian/uterine enlargement/masses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tanner Stage? _____</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p>Ano-Rectal:</p> <p>Hemorrhoids? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prolapse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fissures? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pilonidal abscess? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fistula? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Deferred? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>
<p>MS and Extremities:</p> <p>Joint pain (knee, shoulder, elbow)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Muscle strength 5+ in UE and LE? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congenital/traumatic defects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Varicose veins? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Orthopedic impairments? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ingrown Toenails? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p>Neurological:</p> <p>Gait and coordination WNL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Two-point discrimination Intact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Temperature, vibration , & touch intact ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stereognosis intact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Graphesthesia intact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Reflexes 2+? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Speech WNL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Alert & oriented x 3? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Babinski? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Romberg? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent and Remote memories intact? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>
<p>Breasts:</p> <p>Lumps or masses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nipple discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Deferred? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	

Grafton Bio-Psychosocial Evaluation

Physical Examination

Assessment				
Plan				
Certifications:				
<p>This is to certify that I have examined the above-named individual and have found him/her in good general health and free from all contagious diseases. He/she may participate in the athletic program (except as noted above).</p> <p>This is also to certify that the above-named individual has been successfully immunized against communicable disease, i.e. polio, measles, rubella, diphtheria, pertussis, tuberculosis, and tetanus, as required by Virginia law, or is in the process of completing immunizations. (See attached Immunization Record)</p> <p>Recommendations for further treatment, immunizations, and other examinations as stated above.</p>				
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none; vertical-align: top;">Examining Physician PA/NP: _____</td><td style="width: 50%; border: none; vertical-align: top;">Examination Date: _____</td></tr><tr><td style="border: none; vertical-align: top;">_____ Physician's Signature</td><td style="border: none; vertical-align: top;">Address: _____ _____ _____ _____ Phone Number: _____</td></tr></table>	Examining Physician PA/NP: _____	Examination Date: _____	_____ Physician's Signature	Address: _____ _____ _____ _____ Phone Number: _____
Examining Physician PA/NP: _____	Examination Date: _____			
_____ Physician's Signature	Address: _____ _____ _____ _____ Phone Number: _____			