Fuelling & Associates, LLC

407 E. Russell Rd., Bldg. A, Ste. 5
P.O. Box C
Warrensburg, MO 64093-3107
660-429-6678

MEDICAL SCREENING

This is a confidential medical screening to determine the need for a physical examination and other treatment or medical care. If any of the questions are answered yes, an examination by a physician will be requested, although you may already be under a physician's care for the condition(s) you note. Please indicate if any of the following have occured in the past 30 days:

( ) Yes ( ) No Convulsions or seizures
( ) Yes ( ) No Unconsciousness
( ) Yes ( ) No Fainting or light-headedness and passing out
( ) Yes ( ) No Disorientation as to time, place or person
( ) Yes ( ) No Hallucinations, delusions, illusions or altered perceptions
( ) Yes ( ) No Unusual and/or heavy bleeding
( ) Yes ( ) No Persistent unexplained pain
( ) Yes ( ) No Shortness of breath or difficulty catching breath
( ) Yes ( ) No Persistent Chest Pain
( ) Yes ( ) No Severe Vomiting
( ) Yes ( ) No Severe headache with blurring of vision
( ) Yes ( ) No Severe bruises from an accident
( ) Yes ( ) No Untreated fractures
( ) Yes ( ) No Self-injection of illicit drugs
( ) Yes ( ) No Unprotected casual sexual contact
( ) Yes ( ) No Suicide attempt or phychiatric related hospitaliztion in the last 90 days
( ) Yes ( ) No Exposure to contagious/communicable disease(s)

Date of last physical examination: _____ Physician: _____

Client's Signature: _____ Date: _____

(DO NOT WRITE BELOW THIS LINE)

_____ Medical Evaluation Not Required (only if ALL of the above were checked NO and there is no lethality risk or impaired MSE)

_____ Medical Evaluation Required (if ANY of the above were checked YES or there is lethality risk or impaired mental status)

( ) Client/Patient is presently under Dr. _____'s care for the above.

( ) Client/Patient is referred to Dr. _____ or ( ) to his/her PCP for followup.

( ) Client/Patient refuses medical evaluation: _____ (Client's initials).

If client/patient refuses medical evaluation, the therapist must determine it is appropriate to continue in treatment, and what referral or other options exist. Documentation of refusal to seek appropriate medical treatment should be documented in the progress notes.

_____ _____
Therapist Signature Date

Instructions: Mark either item one ("required") or two ("not required"), based upon the patient/client's answers. If the answers and the therapist's clarification indicate a physician's care is medically indicated, note if the patient/client is currently under a physician's care for the above noted condition or illiness. if the person is not presently under a physician's care, provide the name, phone number and address of the physician or the nearest Emergency Room, and document acceptance or refusal.