Union Point Campus 1061 Mercer Circle Union Point, GA 30669
Alapaha Campus 15320 Highway 129 Alapaha, GA, 31622
Lavonia Campus 1150 Bear Creek Rd. Lavonia, GA, 30553

"Reclaiming Alcohol and Drug Addicted Men and Women through Christ and Christian Love." II Corinthians 5:17

Nursing Assessment

Name____**Date**____________________

Date of Birth_________________________**Primary Care Physician**____________________________________

Medications

List ALL current medications, supplements, vitamins, over-the-counter, and how often you take them:

Medication Name	Dose	Frequency	Prescribed
			▢ Yes ▢ No
			▢ Yes ▢ No
			▢ Yes ▢ No
			▢ Yes ▢ No
			▢ Yes ▢ No

Alcohol and Drug Abuse

Do you drink alcohol? ▢ Yes ▢ No If Yes, when was the last time you drank alcohol? ___________________________

If Yes, how often and how much do you drink? ____

Do you use any illegal drugs, or take medications not prescribed to you? ▢ Yes ▢ No If, yes please answer below:

Drug Name	How Often	How Much	
			Last Use within seven days ▢ Yes ▢ No
			Last Use within seven days ▢ Yes ▢ No
			Last Use within seven days ▢ Yes ▢ No
			Last Use within seven days ▢ Yes ▢ No

Tobacco History

Have you ever smoked cigarettes? ▢ Yes ▢ No Currently? ▢ Yes ▢ No

If Yes, how many packs per day on average?__________________For how many years? _________________

Medical History

Allergies____Current Weight____________Height____________

Do you have any trouble walking, writing, speaking, hearing, or seeing? ▢ Yes ▢ No If Yes, please explain ____________

____

Are you currently being treated for an infectious disease such as, but not limited to MRSA, HIV, AIDS, Hepatitis, and / or Tuberculosis? ▢ Yes ▢ No If Yes, please explain. ____

Have you ever been treated for any of the following:

▢ Seizures	▢ Brain Injury / Head Trauma	▢ Stroke	▢ Hepatitis	▢ Cancer
▢ High Cholesterol	▢ Heart Disease	▢ Rheumatic Fever	▢ Anemia	▢ Heart Attack
▢ High Blood Pressure	▢ Staph Infections	▢ Asthma	▢ Tuberculosis	▢ COPD Emphysema
▢ Diabetes	▢ Thyroid Problems	▢ Liver Problems	▢ Stomach Problems	
▢ STDs	▢ Kidney / Bladder Problems	▢ HIV / AIDS	▢ Sexual Problems	
▢ Substance Abuse	▢ Anxiety	▢ Depression	▢ Other mental problems	

Please list any past surgeries

___

___

Physical Assessment

Is the client alert and oriented to person place time and situation? ▢ Yes ▢ No

Breathing within normal limits	▢ Yes ▢ No	Nutrition within normal limits	▢ Yes ▢ No
Bowel / Bladder function within normal limits	▢ Yes ▢ No	Musculoskeletal within normal limits	▢ Yes ▢ No
Any open wounds	▢ Yes ▢ No	Circulation within normal limits	▢ Yes ▢ No
Respirations within normal limits	▢ Yes ▢ No	Dental problems	▢ Yes ▢ No

If No, please explain. ___

___

For women only

Date of last menstrual period___ Are you currently pregnant or could you be pregnant? ▢ Yes ▢ No.
Are you planning to get pregnant in the near future? ▢ Yes ▢ No Birth control method___

Suicide Risk Assessment

1. Have you recently had feelings, or thoughts that you didn't want to live? ▢ Yes ▢ No. If yes, please explain
   ___
2. Have you recently tried to kill or harm yourself before? ▢ Yes ▢ No If yes, please explain.___
3. Do you currently have feelings or thoughts that you do not want to live? ▢ Yes ▢ No If yes, please explain
   ___

Vital Signs

Blood pressure___/___Pulse ___ Respirations___Pulse Oximetry___Temperature ___

PPD: Date placed___Location ▢ right arm ▢ left arm

Date read ___ Read By___MM of Induration ▢ Positive ▢ Negative

Client's with a positive TB test must follow up with the local health department for evaluation.
RPR: Date drawn___Date resulted___is further treatment needed ▢ Yes ▢ No

Do you agree to fax a copy of the RPR results to 1-888-785-0613? ▢ Yes ▢ No

Based on your assessment, are there any concerns that need to be addressed before the client attends a substance abuse program? ▢ **Yes** ▢ **No If Yes, please explain.** ___

___

Based on your assessment, is there any reason why the client cannot participate in a substance abuse recovery program? ▢ **Yes** ▢ **No If Yes, please explain.** ___

Based on your assessment, does the client require detox from Benzodiazepines, or Alcohol before going to a substance abuse recovery program? ▢ **Yes** ▢ **No If Yes, please explain.** ___

Name of facility where assessment was completed: ___
Facility phone number: ___
Printed name and title of staff completing assessment: ___

Signature of professional completing assessment:___**Date:** ___

Please attach any additional information you feel necessary.