



JABA's Adult Care Center
522 Industrial Dr., Suite B, Louisa, VA 23093
Phone: (540) 967-4432 Fax: (540) 967-4452

Participant History and Physical Form

Report of Participant's Physical Examination - initial to be completed not more than 30 days prior to the date of acceptance for admission, with updates completed annually. The participant cannot be admitted nor retained in daycare without these completed physicals. This report will be kept as part of the client's permanent record. Please fill in every section.

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TEL: # \_\_\_\_\_

1. Date/ Place of Examination: \_\_\_\_\_

BP \_\_\_\_\_ / \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_
Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

Diagnoses:

Primary: \_\_\_\_\_

Contributory: \_\_\_\_\_

Secondary: \_\_\_\_\_

Present Level of Cognitive Functioning: \_\_\_\_\_

General Appearance:

EENT: \_\_\_\_\_ Neck: \_\_\_\_\_
Chest: \_\_\_\_\_ Heart: \_\_\_\_\_
Abdomen: \_\_\_\_\_ Spine: \_\_\_\_\_
Extremities: \_\_\_\_\_ Skin: \_\_\_\_\_
Pelvic: \_\_\_\_\_ Rectal: \_\_\_\_\_

History of Illnesses:

Arthritis \_\_\_\_\_ Alzheimer's \_\_\_\_\_ CVA \_\_\_\_\_
Cancer \_\_\_\_\_ Other Dementia \_\_\_\_\_ Heart Disease \_\_\_\_\_
Diabetes \_\_\_\_\_ Dizziness \_\_\_\_\_ Hypertension \_\_\_\_\_
Kidney Disease \_\_\_\_\_ Neurological \_\_\_\_\_ Parkinson's \_\_\_\_\_
Tuberculosis \_\_\_\_\_ Seizures \_\_\_\_\_ Thyroid \_\_\_\_\_
Allergies \_\_\_\_\_ Depression \_\_\_\_\_ Other \_\_\_\_\_

Please list any previous hospitalizations for injury, surgery, illness, etc.: \_\_\_\_\_

\_\_\_\_\_

Please list all known medicinal and food allergies: \_\_\_\_\_

\_\_\_\_\_

Any other allergies? (Ex. latex, bee stings) \_\_\_\_\_

Is this person capable of administering his/her own medication without assistance? \_\_\_\_\_

2. **DATE of screening for TUBERCULOSIS** according to accepted methods of the Virginia Department of Health: **Type of Test:** \_\_\_\_\_

**TEST DATE:** \_\_\_\_\_ **DATE READ:** \_\_\_\_\_

**Test Results:** \_\_\_\_\_

Standards permit the initial screening for tuberculosis to be the tuberculin skin test. Each person, whose physician certifies the absence of tuberculosis in a communicable form, even though the test is significant (positive), must obtain a chest X-Ray on an annual basis for the following two years.

This person is \_\_\_\_\_, is not \_\_\_\_\_, free of tuberculosis in a communicable form.

If it is medically inappropriate for this person to have a tuberculin test, please check. \_\_\_\_\_

**\*\*THE PATIENT MUST BE TESTED FOR TUBERCULOSIS NO MORE THAN 30 DAYS PRIOR TO ADMISSION TO THE FACILITY.**

Does this person have a condition that requires isolation? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Date of positive test: \_\_\_\_\_ Next date for organism testing: \_\_\_\_\_

3. **Recommendations for care:**

A. Diet (check one): Regular \_\_\_\_\_ No Salt Added \_\_\_\_\_ No Concentrated Sweets \_\_\_\_\_

Patient requires foods: Chopped \_\_\_\_\_ Pureed \_\_\_\_\_ Needs Ensure Daily \_\_\_\_\_

Foods client should **not** have (such as nuts or milk products) \_\_\_\_\_

B. Specific treatments and/or therapies: \_\_\_\_\_

C. Please indicate the condition of the client's teeth and oral health. \_\_\_\_\_

\_\_\_\_\_

**D. Medications & Dosages: THIS SECTION IS A MUST, PLEASE WRITE CLEARLY**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- E. Which of the following over-the-counter medications may we administer as needed:
- \_\_\_\_\_ Tylenol, 325 mg 2 tablets every 4 hours, prn for pain or fever. If symptoms persist after 2 doses, call physician for further instructions.
  - \_\_\_\_\_ Maalox, 30 cc., q day, prn for complaints of indigestion. After 1 dose, call physician for further instructions.
  - \_\_\_\_\_ Imodium A-D, 2 tablets prn after third loose stool, for diarrhea. If symptoms persist after one dose, call physician for further instructions.
  - \_\_\_\_\_ Neosporin Ointment, prn for minor skin abrasions. If symptoms of redness or swelling develop, call physician for further instructions.

- F. **Mental Condition:**
- Has patient been hospitalized for mental illness? \_\_\_\_\_
- If so, what diagnosis: \_\_\_\_\_
- When and how many times? \_\_\_\_\_
- Results: \_\_\_\_\_
- Any history of aggressive behavior or dangerously agitated states: \_\_\_\_\_
- \_\_\_\_\_
- Senility: Slight \_\_\_\_\_ Moderate \_\_\_\_\_ Advanced \_\_\_\_\_
- History of drug addiction or excessive alcohol intake: \_\_\_\_\_

4. Does this person need any type of restraint to provide physical support because of a weakened condition? \_\_\_\_\_
5. In your opinion, is your patient's physical condition such that in an emergency he/she can exit from the building without assistance from another person? \_\_\_\_\_
6. In your opinion, does this person have the sensory and mental ability to perceive an emergency and exit from the building without the assistance of another person? \_\_\_\_\_

7. Does the individual have any of the following conditions or care needs?

Dermal ulcers or wounds which are open? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Any infectious disease in a communicable state which requires isolation or special precautions to prevent transmission? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Does this person require skilled nursing care for ventilator dependency, intravenous therapy, Nasogastric, Gastric Tubes or any type of skilled nursing care not listed? \_\_\_\_\_ Please describe: \_\_\_\_\_

8. Please list any other restrictions on physical activities beyond those noted in the History and Physical? \_\_\_\_\_  
\_\_\_\_\_

9. Does the client have Advanced Directives? \_\_\_\_\_  
Does the client have a "DNR" Order? \_\_\_\_\_ **Please note, we must have a copy for the JABA Adult Care Center.**

10. Further comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Date

Please print or type the physician's name, address, telephone and fax numbers:

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

JABA's Adult Care Center is licensed by the Department of Social Services, Commonwealth of Virginia. Participants in need of skilled nursing care qualify for Medicaid, provided they meet financial criteria.