Main Campus 1061 Mercer Circle Union Point, GA 30669
South Campus 15320 Highway 129 Alapaha, GA 31622
Heart 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 do you drink ▢ daily ▢ weekly ▢monthly, and how much do you drink _____ when 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. _____
   _____

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.

Last revision date 09/19/18