Ka-Na-Chi-Hih
Treatment Centre

UNIVERSAL MEDICAL ASSESSMENT FORM FOR ALL TREATMENT CENTRES

MEDICAL FORM FOR: **ADULT** (18 and over) ☐
CHILD (17 or younger) ☐

DATE OF EXAM: ________________

Addressograph

Please complete this section in a **CLEAR** manner.
For physicians, please complete in **FULL.**

PATIENT'S NAME: ______________________________________ **How do you Identify?** **Male** ☐

DATE OF BIRTH: ______________________________________ **Female** ☐

STATUS CARD #: ______________________________________ **2-Spirited** ☐

HEALTH CARD #: ______________________________________

MEDICAL HISTORY (Please explain any 'YES' responses in section)

Conditions	Yes	No	If Yes, Explain?
Anemia	☐	☐	
Back Injury / Problems	☐	☐	
Brain Injury	☐	☐	

Cardiovascular Problems	☐	☐	
Cognition Problems	☐	☐	
Chicken Pox	☐	☐	
Disease / Injury of Bones	☐	☐	
Diabetes / Hypoglycemia	☐	☐	
Ear, Nose, Throat Prob.	☐	☐	
Eating Disorders	☐	☐	
Eye Problems	☐	☐	
Epilepsy	☐	☐	
Fainting	☐	☐	
Hallucinations / Delusions	☐	☐	
Heart Problems	☐	☐	
Hepatitis (A, B, C) Indicate, if yes	☐	☐	
Respiratory Problems	☐	☐	
Gastrointestinal Problems	☐	☐	
Pancreatic Problems	☐	☐	
Kidney or Urinary Problems	☐	☐	
Learning Disability	☐	☐	
Tuberculosis	☐	☐	
Chronic Pain	☐	☐	
Sleep Disorders	☐	☐	
Withdrawal Symptoms	☐	☐	
Mental Health Challenges	☐	☐	
HIV / AIDS	☐	☐	
Sexually Transmitted Disease	☐	☐	
Allergies (Drug, Food, Other)	☐	☐	
Suicidal Ideations	☐	☐	

A. Current Medications Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. Please note, mood altering medications must be prescribed and monitored by a psychiatrist for management of a mental illness. If more space is required, attach a current medication list with the application.

Medication	Dose	Frequency	Start Date	End Date	Indication

Reminder to health professional: For the client's safety and well-being while attending our 'facility of healing' please ensure that they bring enough of their medications (in the original packaging from the doctor or pharmacist) for their time in treatment. (6 Weeks/3Months)

In your opinion, is this client medically stable and appropriate for admission to a residential addiction treatment program?

Yes ☐ **No** ☐

Does the client have any communicable diseases?

Yes ☐ **No** ☐

If yes, please list:

Communicable Disease	Condition and/or Treatment

Has there been any disease outbreaks in the client's region? (Tuberculosis/COVID-19/etc)

Yes ☐ **No** ☐

If yes, please explain:

____

____

____

____

Does the client need any special, physical or psychological needs or disabilities?

Yes ☐ **No** ☐

If yes, please explain:

____

____

____

____

In the past 6 months, has the client been using the medication appropriately?

Yes ☐ **No** ☐ **N/A** ☐

If no, please explain:____

____

____

____

Has the client been vaccinated for COVID-19?

No ☐ **Yes (1st Shot Only)** ☐ **Yes (2 shots)** ☐ **Yes (2 Shots plus booster)** ☐

B. PHYSICAL EXAMINATION

Height: __________ Weight: __________ Blood Pressure: __________ Pulse: __________

Area	NO CONCERNS	Area	NO CONCERNS
Cardiovascular	☐	**Musculoskeletal System**	☐
Cognition	☐	**Neuropsychiatry**	☐
Ears, Nose, Throat (System Review)	☐	**Lymph Nodes**	☐
Eyes	☐	**Respiratory**	☐
Mental Health	☐	**Other:** ____________________________________	☐

Is the Client Pregnant? **No** ☐ **Yes** ☐ **How far along is the pregnancy?** ____

Can the client attend sweats and/or long exposures to heat? **No** ☐ **Yes** ☐

C. CONTACT INFORMATION OF HEALTH PROFESSIONAL

HEALTH PROFESSIONAL'S FULL NAME (PRINT): ____

JOB TITLE: ___________________________ DATE: ________________________________

ADDRESS: ___________________________

PROVINCE/TERRITORY: __________________ POSTAL CODE: __________________________

PHONE: ____________________________ FAX: _________________________________

Email: _____________________________ License Number # ________________________

HEALTH PROFESSIONAL'S SIGNATURE: _______________________________________

CLIENT CONSENT TO RELEASE INFORMATION

I hereby authorize the above-named health professional to release the information to the appropriate 'Healing facility' and Intake Coordinator, as required my suitability for acceptance and admittance into the treatment program.

____ ____________________

PARENT/LEGAL GUARDIAN/CLIENT SIGNATURE DATE