SCOTT KEY CENTER
HELPING SHAPE FUTURES

Physical Examination Form

(For Use upon Admission to Program and Annually)

Name: _____ Date: _____

Weight: _____ Height: _____ Temperature: _____

Blood Pressure: _____ Pulse: _____ Respirations: _____

General Appearance: _____

_____

Nutritional Status: _____

_____

1. Head: _____ Skin: _____
2. Eyes: Vision Screening: Right Eye: _____ Left Eye: _____

   Test Used: _____

   Conjunctiva: _____ Sclera: _____

   Cornea: _____ Pupils: _____ Lens: _____

   Fundi: _____
3. Ears: Auditory Acuity: Right Ear: _____ Left Ear: _____
4. Nose: _____
5. Mouth (Gums and Tongue): _____
6. Teeth: _____
7. Pharynx: _____
8. Neck: _____
9. Thyroid Gland: _____
10. Lymph Nodes: _____
11. Chest: _____
12. Lungs: _____
13. Heart: _____ Peripheral Pulses: _____

14. Breasts: _____

15. Abdomen: _____

16. Genitalia: _____ Hernia: _____

17. Rectal: _____

18. Extremities: _____

19. Neurological:

Orientation: _____

State of Consciousness: _____

Cranial Nerves: _____

DTR: _____

Pathological Reflexes: _____

Muscle Strength: _____

Gait: _____

Tone: _____

Involuntary Movements: _____

20. Joints (contractures): _____

21. Spine (describe any curvature): _____

22. Tardive Dyskinesia (perform screening on attached Screening Scale). If client is receiving behavior modifying drugs at the time of the examination or has received them in the past year.

23. Any Allergies: _____

24. Diagnosis:

25. Recommended frequency for Physical Exams:

26. Any special dietary requirements:

_____

(Signature and Title of Individual Performing Examinations and Completing Form)