



Adult & Teen Challenge Heartland

Health Screening Form

To Be Completed By Physician Only

Confidential Information: Available only to necessary ATC Staff

Today's Date:

Name of Applicant: _____

Date of Birth: _____

Present Illnesses/ Complaint/ Disabilities, if any:

History of chronic or major illnesses:

Surgical History:

Hospitalizations: _____

List ALL Allergies: _____

***Medication Currently Prescribed Dosage Diagnosis**

Applicant is able to do the following (Yes/No)

Stand on feet for up to 3 hours at a time ____

Lift up to 50 pounds ____

Bend at the knees ____

Bend at the waist ____

***If applicant arrives at Adult & Teen Challenge of Memphis & Clarksville with medications or diagnosis not listed here, applicant will be refused admission until discrepancy is resolved.**

To your knowledge, has client been exposed to any communicable diseases:

Yes _____ No _____

If yes, please specify:

Physical
Examination

Height _____ Weight _____ BP _____ HR _____ bpm Resp _____ Temp _____

S- Satisfactory U-Unsatisfactory O-Not Examined:

Nutrition _____

Head _____

Ears _____

Hearing: R _____ L _____

Eyes _____

Vision w/o glasses: R _____ L _____

Nose _____

Throat _____

Mouth/Teeth _____

Neck/Thyroid _____

Chest _____

Cardiac _____

Skin_____

Abdomen_____ Genitalia/Hernia_____ Neuro_____ Musculo
Skeletal_____

Required Blood Tests: *Attach computer print out of all test results.*

Syphilis_____

Hepatitis B & C_____

HIV_____

Other Required Tests for STDs

Chlamydia_____

Gonorrhea_____

If positive, date treated: _____

Required Tests: *Attach computer print out of all test results*

Optional Tests: *Attach a computer print out of all test results.*

LFT (Liver Function Tests_____ C

MP/BMP/Chem Panel_____

General comments, assessments, and recommendations:

Signature of examining Physician: _____

Signature Address & Phone Number