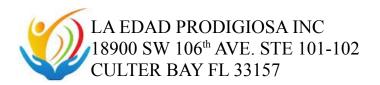


PARTICIPANT HEALTH ASSESSMENT

Patient's Name:						
Date of Birth:// Gender: □ Male □ F		Age:	Height:	W	eight:	Ibs.
1. Medical History & Diagnos						
2. Allergies:					wn Allerg	gies
3. Physical or Sensory Limita						
4. Cognitive or Behavioral St	atus:				_	
5. Should the participant be ractivities at the Adult Day Ca (Specify):	restricted for	or any medic such as walk	king, exercise	e, etc.? 🗖 N	O TYP	ES
6. Any psychiatric history?	INO 🗆 Y	ES (Specify)):			
7. IS PATIENT FREE OF CO	OMMUNIC	ABLE DISE	EASES?			
☐ YES – This patient is FRE signs and symptoms of other communicating disease to any	communica	able diseases	and does no	t constitute		
□ NO (Specify):						



8. Is participant abl Center? ☐ YES 〔		r his/her medication	while at the Adult Day Care	
9. Special Diet Instr ☐ Low Fat / Low C		r 🗖 Diabetic Diet 🗖 🛚	No Salt Added 🗖 Low Salt	
Other special diet in	nstructions:			
10. Please list all cu OR □ See attached		including dosage and	d time medication is to be take	'n
1				
2				
4 .				
7				
			health assessment and examing her physically able to participa	
Date of Examinatio	n:			
Physician's Name:		Sign	nature:	
Date:				
Medical License #:		Геl#:	Fax#:	
Physician's Address	s:			
-	City	State	Zip	