THE Chanan Foundation

Individual Information:

Full Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Phone:** _____

Address: _____

Legal Status (Circle One): **Competent** **Adjudicated Incompetent** **Minor**

Legal Guardian/Emergency Contact:

Name and phone: _____

Legal Guardian? Y N **Relationship:** _____

Current Health Information:

Known Allergies:

_____

_____

Current Diagnoses:

_____

_____

_____

_____

_____

_____

Hospitalizations, Surgeries, and Major Illnesses: (Reason and date)

_____

_____

_____

_____

Current Support Needs for ADL's:

Ambulation	Independent	Supervision	Assistance	Total Care
Bathing	Independent	Supervision	Assistance	Total Care
Dressing	Independent	Supervision	Assistance	Total Care
Eating	Independent	Supervision	Assistance	Total Care
Toileting	Independent	Supervision	Assistance	Total Care
Communication	Independent	Supervision	Assistance	Total Care

Page 1 completed by: _____ **Date:**_____

General Physical Examination:

Weight: _____ **Height:** _____ **Blood Pressure:** _____ **Pulse:** _____

Respirations: _____ **Temperature:** _____ **Other (Specify):** _____

	Normal Findings?	Comments
Eyes	€ Yes € No	
Ears	€ Yes € No	
Hearing Screening	€ Yes € No	
Nose	€ Yes € No	
Mouth/Throat	€ Yes € No	
Head/Face/Neck	€ Yes € No	
Lungs/Chest/Breasts	€ Yes € No	
Skin/Lymph Nodes	€ Yes € No	
Cardiovascular	€ Yes € No	
Abdomen	€ Yes € No	
Gastrointestinal	€ Yes € No	
Musculoskeletal	€ Yes € No	
Neurological	€ Yes € No	
Respiratory	€ Yes € No	
Motor Function/ Extremities	€ Yes € No	

New/Changed Diagnosis: _____

Medication Changes Today: _____

Dietary Restrictions (calorie-restricted, ADA, low sodium, etc.): _____

_____

Choking Risk:

€ Minimal Risk/Regular Diet € Low Risk/Bite-Size Diet € Moderate Risk/Chopped Diet
€ High Risk/Ground Diet € Pureed/Individual Swallow Precautions (Attach specific precautions)

Change in Overall Health from Previous Year? € No € Yes (Specify): _____

_____

Is the person free of communicable diseases? € Yes € No (Specify with precautions to prevent the spread of disease to others): _____

_____

Can this person be cared for in a non-clinical setting (Personal Care Home/Community Living Arrangement? € Yes € No

Physician/Clinician Printed Name: _____ **Date:** _____

Signature: _____