



Adult Day Care & Adult Day Health Programs Managed by Arcadia Elder Services

CUC Adult Day Care & Day Health Center

Kilohana Adult Day Care Center

HISTORY & PHYSICAL FORM

(To be completed by physician)

I. PERSONAL INFORMATION

Name _____ Address _____
 Marital Status _____ Birthdate _____ Age _____ Sex _____ Race _____
 Physician _____ Address _____
 (Please Print) (#, street, suite #, city, zip)
 Telephone _____ Physician's Exchange _____

II. PERTINENT MEDICAL HISTORY (Attach discharge summaries)

Major Medical Problems _____ Yes _____ No Specify _____
 Allergies _____ Yes _____ No Specify _____
 Surgeries _____ Yes _____ No Specify _____
 Psychiatric History _____ Yes _____ No Specify _____

III. PHYSICAL EXAMINATION

General: Height _____ Weight _____ BP _____ Pulse Rate _____

Depressed	<input type="checkbox"/>	Combative	<input type="checkbox"/>
Disoriented	<input type="checkbox"/>	Noisy	<input type="checkbox"/>
Agitated	<input type="checkbox"/>	Noncommunicative	<input type="checkbox"/>

EENT: _____
 Vision _____
 Hearing _____
 Neck _____
 Lungs _____
 Heart _____
 Back-Skeletal _____
 Abdomen _____
 Genitalia/Pelvic _____
 Rectal _____
 Extremities _____

Ambulation Independent Device _____ Assistance
 Total Incapacity History of Falls _____

IV. Two Step – TB Skin Test or Chest X-Ray: Date _____ Result _____
 Date _____ Result _____

(Regulations require annual TB clearance)

V. PHYSICAL AIDS: Dentures Eyeglasses Hearing Aid Colostomy



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Prosthesis Specify _____

VI. ACTIVITIES OF DAILY LIVING

	Urine	Bowel	Foley Catheter	Condom
Continent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recommended Training:	<input type="checkbox"/> Bladder		<input type="checkbox"/> Bowel	

	Independent	Assistance	Dependence
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. CURRENT PHYSICIAN ORDERS

Diet: Regular Special _____ NG Tube Gastronomy
 Routine Vital Monthly: No Yes Other _____
 Appropriate range for this individual _____

Present Medication (Name, Dosage, Time)	
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

May aspirin be given? Yes No Reason _____

VIII. DIAGNOSIS

Primary _____

 Secondary _____

IX. CURRENT PROBLEMS &

ANCILLARY SERVICE REQUIRED

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

IX. REHABILITATIVE POTENTIAL

Good Fair None Custodial Terminal

XI. Participants may participate in sitting/standing exercises for older adults Yes No

Comments _____

I certify that the patient's medical condition and related needs are essentially as indicated above and care in this facility is medically necessary:



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Physician's Signature

Date