Jenesse Center, Inc.
DOMESTIC VIOLENCE INTERVENTION PROGRAM

Site_____ **Jenesse Client Code#**_____

Health Assessment

Today's Date: _____ Program Entrance Date: _____ Birth Date: _____ Age: _____ Race/Ethnicity: _____

Name: _____ Gender: M ☐ F ☐TG ☐ Cell Phone Number: _____

Address: _____ **Initial Assessment** ☐ **Updated Assessment** ☐

Date of Last Assessment_____

Marital Status: Married☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐

Number of Children: _____ Ages:_____

Health Insurance Information Yes ☐ No ☐
Name of Insurance Co.: _____ Member Number _____

Effective Date: _____ Healthcare Provider Name: _____

Healthcare Provider Address:_____ Date last seen by a healthcare provider:_____

Reason for last visit_____Your next medical appointment is on (date): _____

Gained/Lost more than 10lbs in the last month? ☐Yes ☐No Do you exercise regularly? ☐Yes ☐No
If yes, how long? _____ How often?_____
Do you plan to start? ☐Yes ☐No When?_____

Health History
Please list diagnosis (es) made by any Medical Doctor and/or Psychiatrist
_____

Current medications: _____

In the past 6 months, have you been in contact with anyone with? Hepatitis: ☐Yes ☐No Tuberculosis: ☐Yes ☐No
Chicken Pox: ☐Yes ☐No

Do you currently have any physical pain? ☐Yes ☐No If yes, where?_____ For how long? _____

Vaccines and Immunizations
Flu (annual) ❑Yes ❑No Date:_____
TDAP booster (every 10 years) ❑Yes ❑No Date:_____
Varicella (once after age 18) ❑Yes ❑No Date:_____
HPV (once, ages 19 through 27) ❑Yes ❑No Date:_____
Zoster (age 60+) ❑Yes ❑No Date:_____
Measles, mumps, rubella (once, ages 19 through 57) ❑Yes ❑No Date:_____
Pneumococcal (once, age 19+) ❑Yes ❑No Date:_____
Hepatitis A (3x, age 19+) ❑Yes ❑No Date:_____
Hepatitis B (3x, age 19+) ❑Yes ❑No Date:_____
Meningococcal (once, age 19+) ❑Yes ❑No Date:_____
Meningococcal B (2x, age 19+) ❑Yes ❑No Date:_____
Haemophilus influenza (2x, age 19+) ❑Yes ❑No Date:_____

Have you ever been diagnosed w/ TB? ☐Yes ☐No If yes, when? _____ Treated? ☐Yes ☐No
Date of last TB test date: _____ Results: _____

Special Considerations

Mental Health ❑Yes ❑No Developmentally Disabled ❑Yes ❑No Age 55+ ❑Yes ❑No
HIV/AIDS ❑Yes ❑No Physical Disability ❑Yes ❑No Migrant/Undocumented ❑Yes ❑No
Trans/Gay/Lesbian/Bisexual ❑Yes ❑No

Allergies

Medication(s): _____ Food: _____ Insect Stings: _____

Asthma: _____ Other: _____

Reproductive Health

Are you pregnant? ☐Yes ☐No Date of last menses/menstrual cycle: _____

Method of Contraception: _____

Date of last OB/GYN exam _____ Date of last pap-smear _____ Date of last mammogram _____

Date of last prostate exam (if applicable): _____

Date of last breast exam: _____ Self exam? ☐Yes ☐No

1a. General Questions

Date of last physical exam: _____

Date of last dental exam: _____

Have dental prosthesis? ☐Yes ☐No

Ever been knocked unconscious? ☐Yes ☐No

Ever had seizures? ..... ☐Yes ☐No
If yes, when? _____

Ever had surgery? ..... ☐Yes ☐No
If yes, when? _____

What type? _____

Ever had a head injury? ☐Yes ☐No

If yes, when? _____

Frequent headaches? ..... ☐Yes ☐No

Do you have a heart murmur? ☐Yes ☐No

Wears contact lenses/glasses? ☐Yes ☐No

Do you smoke? ☐Yes ☐No

If yes, how long? _____ How often? _____

Do you plan to quit? ☐Yes ☐No

1b. General Questions

Diabetes? ..... ☐Yes ☐No

Cancer? ..... ☐Yes ☐No

Ever had been hospitalized? ... ☐Yes ☐No

If yes, why? _____

If yes, when? _____

Ever had high cholesterol? ..... ☐Yes ☐No

Ever had skin problems? ..... ☐Yes ☐No
If yes what kind? _____

Abnormal menstrual history? ☐Yes ☐No

Ever had an eating disorder? ☐Yes ☐No

Any other medical conditions not covered?

_____
_____
_____
_____

Previous Illness

Tested for STDs	☐No	☐Yes Date: _____	Results: _____
Treated	☐No	☐Yes Date: _____	
Tested for Hepatitis C	☐No	☐Yes Date: _____	Results: _____
Treated	☐No	☐Yes Date: _____	
Tested for HIV	☐No	☐Yes Date: _____	Results: _____
Treated	☐No	☐Yes Date: _____	

Substance Abuse History
In the past six months, have you abused?

Alcohol ☐Yes ☐No Drugs (recreational/street) ☐Yes ☐No
If yes, have you been treated? ☐Yes ☐No When?:_____ Where?:_____

Sexual Abuse
Have you ever been sexually abused? ☐Yes ☐No age when abuse occurred? _____ Length of time? _____
Have you had more than one abuser? ☐Yes ☐No
Was abuse reported? ☐Yes ☐No
If yes, was anything done to the abuser? ☐Yes ☐No ☐ Don't know

Psychosocial
Client was:

Alert ☐ Confused ☐ Forgetful ☐ Disoriented ☐ Lethargic ☐ Angry ☐ Hostile ☐

Client Behavior during assessment

Cooperative ☐ Anxious☐ Depressed ☐ Demanding ☐ Talkative ☐ Aggressive ☐

Comments: _____

The following health care issues have been identified:

- _____
- _____
- _____
- _____

The following plan will be implemented:

INTERVENTION	RESPONSIBLE PARTY	TIME FRAME	OUTCOME

Referral

√	REFERRAL TYPE	ORGANIZATION/ COMPANY NAME	CONTACT NAME
	Health		
	Dental		
	Vision		
	Other		

_____ _____
Completed by **Date**