PHYSICAL HEALTH ASSESSMENT TOOL

phn MURRAY

An Australian Government Initiative

bendigo Community Health services

Golden City SUPPORT SERVICES

partners in recovery

LODDON MALLEE MURRAY REGION

Name:

General health and lifestyle

Do you have any diagnosed physical health conditions? ☐ **YES** ☐ **NO**

If yes, give details (include both minor and serious conditions)

Go to next question

If yes, are you receiving treatment for these?

List any problems you may have you are not getting treatment for

Do you have a disability or impairment? ☐ **YES** ☐ **NO**

If yes, describe the disability

Go to next question

Have any of your immediate family or deceased relatives (parents, siblings) **had any of the following conditions?** (It is usual to specify under the age of 60 years)

☐ **HEART DISEASE** ☐ **STROKE** ☐ **CANCER** ☐ **DIABETES**

If yes, give details

List all medications you are currently using.
(include psychiatric and non-psychiatric medications, creams, inhalers, complementary treatments and remedies)
If you do not know the names of your medication, indicate this in the table below.

	Name of medication	Dose	Frequency	Date started
1				
2				
3				
4				
5				
6				
7				

Do you have any problems with any of these medications? ☐ YES ☐ NO
(e.g. weight gain, disrupted sleep)
If yes, give details

Go to next question

Do you need information about any of the medications you are currently taking? ☐ YES ☐ NO

Go to next section

Healthcare providers

What Healthcare providers do you have in place?

Provider	Address	Phone	Last visted	Frequency	Tests needed

General daily exercise

Do you take part in any physical activity or exercise?
(walking, cycling, gardening etc.)

☐ YES ☐ NO
Go to next section

If yes, what do you do and how often?

Activity	Time spent per day	Time spent per month
Cleaning		
Gardening		
Gym		
Walking		

General diet

Considering the Australian Guide to Healthy Eating, do you consider your diet to be a healthy?

☐ YES ☐ NO

How many regular meals do you eat a day?

How many times a day do you eat fruit and vegetables?

How many times a week do you eat take away?

What foods to you typically eat on a daily basis?

Food	How much
Bread	
Dairy	
Fruit	
Meat	
Sweets	
Take away	
Vegetables	

Sleep routine

How many hours sleep would you get on a good night?

How many hours sleep would you get on a bad night?

How many bad night's sleep would you average a week?

Would you like information and support on any of the things you have raised?

Improving your diet ☐ YES ☐ NO
(e.g. referral to dietician)

Increasing physical activity ☐ YES ☐ NO
(e.g. walking programs, gymnasium membership)

Stopping or reducing smoking ☐ YES ☐ NO
(e.g. Quit program)

Stoping or reducing alcohol intake ☐ YES ☐ NO
(e.g. ACSO)

Stopping or reducing drug use ☐ YES ☐ NO
(e.g. ACSO)

General sexual health

Are you aware of the risks of sexually transmitted infection? ☐ YES ☐ NO

If no, would you like more information on this? ☐ YES ☐ NO

Would you like further information on any other sexual health issue? ☐ YES ☐ NO
(pregnancy, contraception, impotence etc.)

General alcohol intake

Do you know the recommendations for maximum standard drink consumption is? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Go to next section

How often do you have a drink containing alcohol?

☐ NEVER ☐ MONTHLY ☐ 2-4 TIMES A MONTH

☐ 2-3 TIMES A WEEK ☐ 4 OR MORE TIMES A WEEK

Using the *standard drink chart*, how many standard drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 OR 2 ☐ 3 OR 4 ☐ 5 OR 6 ☐ 7 TO 9 ☐ 10+

How much money a week do you spend on alcohol?

☐ <$10 ☐ $10-30 ☐ $30-50 ☐ $50-100 ☐ >$100

General nicotine use

Do you smoke cigarettes or tobacco? ☐ YES ☐ NO

If yes, how much do you smoke per day?

If no, have you smoked in the past? ☐ YES ☐ NO

If yes, what date did you quit?

Recreational substance use

Do you use recreational or non-prescription drugs? ☐ YES ☐ NO

(e.g. cannabis)

Go to next section

If yes, what do you do and how often?

Substance	How much	How often	Cost ($)

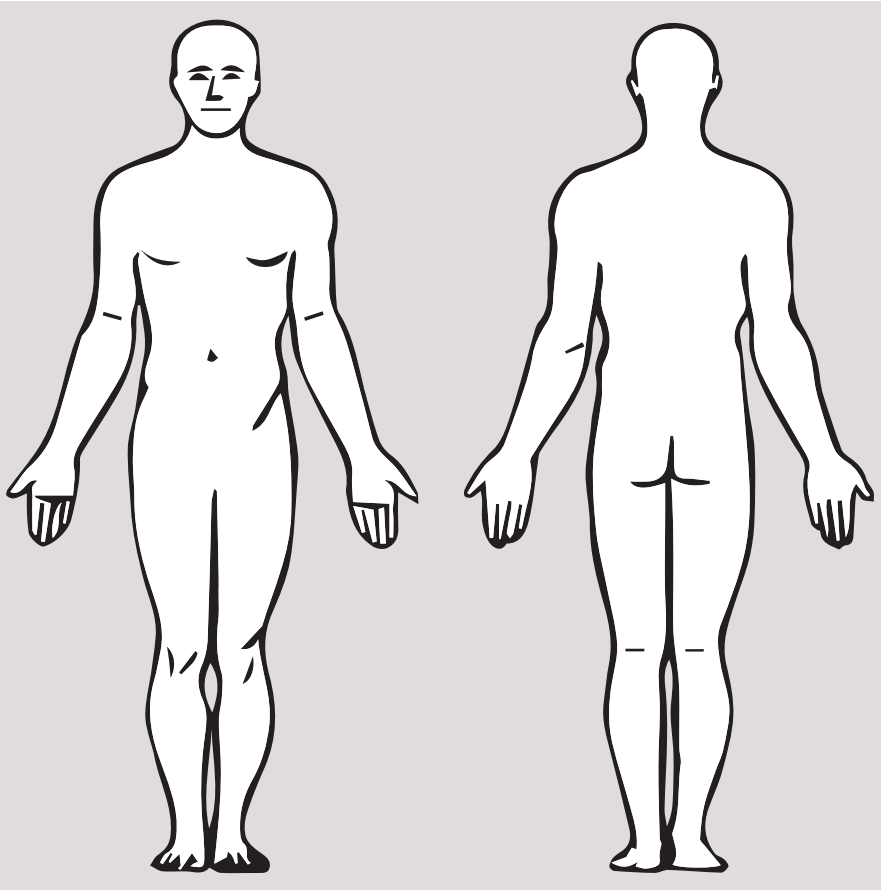
Symptoms checklist

Date of appointment: ...../...../.....

In the table below tick any of these symptoms experienced.

Symptom	Tick
Increased thirst	
Problems with urination	
Breathlessness	
Weight gain (unexpected)	
Weight loss (unexpected)	
Fits/blackouts	
Constipation	
Difficulties having sex	
Chest pain	
Difficulty sleeping	
Loss of feeling in feet	

On each body figures below place a number to indicate any areas where you experience current or regular pain, discomfort or difficulties in your body. *(Please include issues such as skin, dental, feet, ear problems or incontinence.)*
Then use the table below to further explain symptons.



Number	Symptom	Frequency	Impact

Screening checks

Do you have a GP? ☐ YES ☐ NO **Do you have a dentist?** ☐ YES ☐ NO

General health checks	Date/timing	Any other details (reason for visit/result of test)
When did you last visit your GP?		
When did you last visit your dentist?		
When did you last have your eyes tested?		
When did you last have a blood test?		
When did you last have a screening for bowel cancer (50+)?		
When did you last have a chlamydia screening (<25)?		

Checks for women	Date/timing	Any other details (reason for visit/result of test)
When did you last have a Pap smear?		
When did you last have a period?		
How often do you have your period?		
When did you last have a mammogram (50+)?		
When did you last have a screening for bowel cancer 50+?		

Do you check your breasts for lumps or other changes? ☐ YES ☐ NO

If no, would you like more information on this? ☐ YES ☐ NO

Checks for men	Date/timing	Any other details (reason for visit/result of test)
How often do you examine your testicles?		

Are you aware of the increased risk of prostate problems in men aged 50+? ☐ YES ☐ NO

If no, would you like more information on this? ☐ YES ☐ NO

Record the following information if possible

BMI		Waist circumference		Blood preasure		Pulse	
Weight		Height		Blood glucose		Lipids	

Your action plan

In this table indicate any health needs that have been identified and what actions are to be taken.

Name: Date:

Health need identified	What action is to be taken?	By whom?	When is the action to be taken?	Followed up when and by who?	Any other comments?

Summary questions

Are you satisfied with what we have agreed? ☐ YES ☐ NO

If no, give details

Is there anything you are worried about as a result of this questionnaire? ☐ YES ☐ NO

If no, give details

Need any extra support at this time to help you with the next step(s) identified? ☐ YES ☐ NO

If yes, give details

Barriers to accessing services

Have you experienced things that have interfered with your ability to access Physical Health related appointments? ☐ YES ☐ NO

If yes, what are they?

Do you require any form of support to in regards to your appointments? ☐ YES ☐ NO

If yes, what support fo you require?

Is there a specific timeframe that better suits you to attend your appointments? ☐ YES ☐ NO

☐ MORNING ☐ LATE MORNING ☐ EARLY AFTERNOON ☐ LATE AFTERNOON

Do you have any support agencies involved in your care? ☐ YES ☐ NO

☐ MHCSS ☐ PHaMs ☐ CARER SUPPORT ☐ CARER
☐ PIR ☐ LEAD CLINICIAN ☐ DIASBILITY WORKER ☐ HOUSING WORKER
☐ OTHER:

Specify who is involved in your care

Barriers action plan

Identified barrier	What action is to be taken?	By whom?	By when?	Other comments

Healthcare tests

Test	Condition	Frequency of appointments	Next appointment

Notes

ACKNOWLEDGEMENT

This Physical Health for Mental Health workbook is adapted from the “My physical Health. A Physical health check for people using mental health services”, Rethink Mental Illness 2014.