2024

CLEAR HILLS
YOUTH TREATMENT CENTRE

Clear Hills Youth Treatment Centre

MEDICAL ASSESSMENT

MEDICAL ASSESSMENT FORM

Applicant's name:		Health Care Number:	
Treaty Number (10 digits)		Are you the client's regular physician?	☐ Yes ☐ No

A. Medical History: (explain any 'yes' responses in Section B)

	Diagnosed		Tested		Comments
	Yes	No	Yes	No	
Central Nervous System Disorder	☐	☐	☐	☐	
Chronic bronchitis	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Heart problems	☐	☐	☐	☐	
Gastrointestinal problems	☐	☐	☐	☐	
Pancreatic problems	☐	☐	☐	☐	
Kidney or urinary problems	☐	☐	☐	☐	
Diabetes / hypoglycemia	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
Chronic pain	☐	☐	☐	☐	
Eating disorders	☐	☐	☐	☐	
Sleep disorders	☐	☐	☐	☐	
Withdrawal symptoms, seizures, etc.	☐	☐	☐	☐	
Mood disorders (e.g., major depressive disorder)	☐	☐	☐	☐	
Psychotic disorders (e.g., schizophrenia)	☐	☐	☐	☐	
Personality Disorders	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	
Liver problems: Hepatitis B & C	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
Sexually Transmitted Infections	☐	☐	☐	☐	
Medical confirmation of pregnancy	☐	☐	☐	☐	# weeks
Is all related testing complete? ☐ Yes ☐ No	If no, please describe				
Are there any special considerations regarding the pregnancy and pre-natal care we need to be aware of?					
Current blood pressure:					
Doctors Signature:					Date:
Clinic where assessment was completed:					