

Ohio Mental Health and Addiction Services

Initial Health Assessment

OAC [5122-33-18](#)

Date:

Resident Name:

Age: Male
 Female

Facility Name:

License No.:

These components may be performed by different health professionals, consistent with the type of information required and the professionals' scope of practice, as defined by applicable law. If different health professionals are used, each professional must sign the section they complete. If a physician is completing the entire assessment, he/she need to only sign at the end of the form. Use an additional form, or add attachments as needed.

Physical:

Height: BP: Lungs: P:
Weight: Temp: Heart: R:

Health History:

Medical Diagnosis:

Psychological Diagnosis:

List of all current Medication(s)	Frequency	List of all current Medication(s)	Frequency
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Dietary Requirement(s):

