A-663 (ANC)
rev. 6/2026

APL	DIS	Initials/Code

COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

Clinic Code ___________

HISTORY: Chief complaint: ____

HPI: ____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

0 No Hurt | 2 Hurts Little Bit | 4 Hurts Little More | 6 Hurts Even More | 8 Hurts Whole Lot | 10 Hurts Worst

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Illnesses: ____
____
Hospitalizations: ____
Past Surgeries: ____

Medicines: ____
____
____

Allergies: Y N
To what: ______________________ Reaction: ______________________
______________________ Reaction: ______________________

Tobacco: None Chew Smoke Vape
How much: ______________________
How long: ______________________
Thinking about quitting? Y N Referral: Y N
Smokers in home? Y N

Alcohol: Y N What: ______________________
How much: ______________________
How often: ______________________
Last Use: ______________________
(less than 8 years) Alcohol use in the home: Y N

Marijuana: Y N What: ______________________
How much: ______________________
How often: ______________________
Last Use: ______________________
(less than 8 years) Marijuana use in the home: Y N

Drugs: Y N What: ______________________
How much: ______________________
How often: ______________________
Last Use: ______________________
(Less than 8 years) Drug use in the home: Y N

Social: Work outside home? Y N
If yes what? ______________________

Safety: Feels safe at home? Y N
If no why? ______________________

Last TB skin test: _________ Pos Neg
History + test or TB: Y N
When: _____________
Treated: Y N How long: __________

Immunizations UTD: Y N Unsure Flu shot this season: Y N
If no, would you like one today? Y N

High Risk Health Conditions: Y N
List: ______________________
____

LMP: ________________ Normal: Y N Breastfeeding? Y N Do you think you might be pregnant? Y N
Do you use birth control? Y N If yes, what: ______________________
If no, are you trying to get pregnant or would you like more information about birth control? Y N

Prevention: Wants Cancer Screening Visit: Y N
If yes, scheduled Y N If yes, date: __________

Name: (L) ______________________ (F) ______________________ DOB: ____ / ____ / ____ MRN ______________________

CHA/P PATIENT ENCOUNTER FORM PAGE 2 OF 2

EXAM: General Appearance______________________________

VS: T _____° P_____ R____ BP_____/_____ SPO2____% WT ______kg change: ______ HT ______cm HC ______ cm

Head/Sinus:______________________________

Eyes: ______________________________Snellen Test: (R)___/___ (L) ___/___ (B)___/____

Ears:(R)______________________________

(L)______________________________

Nose: ______________________________

Mouth/Throat:______________________________

Neck/Nodes: ______________________________

Back: ______________________________

Lungs/Chest: ______________________________

Heart: ______________________________

Breasts: ______________________________

Abdomen: ______________________________

Genital/Rectal:______________________________

Extremities: ______________________________

Nervous System: ______________________________

Skin: ______________________________

Lab tests/results: ______________________________

Immunizations given: Vaccine / Lot # / initials	TB skin test:
__________ / # ________ / (___) __________ / # ________ / (___)	( ) PPD 0.1mL given ID RFA LFA
__________ / # ________ / (___) __________ / # ________ / (___)	PPD read: ____ / ____ / ____
__________ / # ________ / (___) __________ / # ________ / (___)	_________ mm

ASSESSMENT: ______________________________

____

PLAN (number and title): ______________________________

Standing Orders Used: Y N

Patient/Medicine Education: ______________________________

____

____

Medicines: ______________________________

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____

Special/Other Care: ______________________________

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Recheck/Follow up: ______________________________

Documentation Continued: ______________________________

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Name: (L) ____________________ (F) __________________ DOB ___ / ___ / ___ MRN ______________ Phone# ____________

Gender: M F Other CHA/P: ______________________________ Village: ____________________

Date: ____ / ____ / ____ Referral Provider: ____________________ Provider's Assessment: ____________________

Time:__________ Normal Clinic Hours: Y N After Clinic Hours: Y N ETOH Related: Y N ____________________

(CONTINUATION) CHA/P PATIENT ENCOUNTER FORM

Date: ____/____/________ Time:_________
Name(L)_________________ (F)___________
DOB:____/____/________ Age____ Sex____

Standing Order □______________________________
Village: ____________________________________
CHA/CHP:____________________________________