

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

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 ☐ N/A ☐
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 ☐ N/A ☐
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 _____ / # _____ / () _____ / # I _____ / () _____ / # _____ / () _____ / # _____ / () _____ / # _____ / () _____ / # _____ / ()	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: _____

Special/Other Care: _____

Recheck/Follow up: _____

Documentation Continued: _____

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

Lined area for patient encounter notes.

Date: ____/____/____ Time: ____
Name(L)____ (F)____
DOB:____/____/____ Age____ Sex____

Standing Order ☐ ____
Village: ____
CHA/CHP: ____