



Medical Pre-Treatment Form

To be completed by a Health Care Practitioner

Date: _____ Patient: _____

Address: _____

PHYSICAL ABILITY CLEARANCE:

Person is capable of walking up/down stairs safely several times a day? yes no

Person may participate in the following activities: Walking ___Running ___Lifting ___Bending ___

At the following level: Light ___Moderate ___Strenuous ___

If person is NOT CLEARED for participation in any activities, please give reason:

Are there are any other medical conditions of which the House of Sophrosyne should be aware:

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> diabetes | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> musculo-skeletal injuries | <input type="checkbox"/> physical defects | <input type="checkbox"/> chronic fatigue syndrome | |
| <input type="checkbox"/> fibromyalgia | | | |
| <input type="checkbox"/> other: _____ | | | |

Comments: _____

COMMUNICABLE DISEASE:

Is this person free from clinical manifestations of Staph. Infections including MRSA? yes no

If no, please state findings and interventions: _____

MEDICATION: Client's are able to access their medication up to four times a day. 0745,1245,1745, 2215 Food is available if required. Are there any reasons why this patient cannot take their medication during the times available? yes no

If yes, Please explain: _____

The House of Sophrosyne requires all medication be blistered packed prior to admission. Client will require a 5 weeks supply of their medication for the duration of the program.

Medication and Dosage	Medication and Dosage
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Health Care Practitioner Name: _____ Phone Number: _____

Health Care Practitioner Signature: _____ Date: _____