

My physical health.

**Challenging attitudes, changing lives.**

**PHC (Physical Health Check)**

**It is recommended that prior to completing the PHC with people who use our services it is introduced in the following way:** the PHC is designed

to help you to identify (in conjunction with a health professional) any physical

health needs you might have. The Action Plan at the end of the PHC offers the

opportunity to address any identified needs. All information on this form will be treated as **CONFIDENTIAL**. One copy of the PHC will be filed with your notes and you will also be given a copy to keep.

**Name of the person who uses our services**

**Date of birth**

**Date of completion Name of assessor**

**Job role**

**The development of the PHC**

The PHC was originally developed by Dr Michael Phelan, Linda Stradins, Dipti Amin, Anne Doyle, Rik Inglis (West London Mental Health Trust), Rachel Isadore (Hammersmith and Fulham Social Services) and

Christine Hitrov (Central and North West London Mental Health Trust).

The current PHC has been developed by Rethink Mental Illness in collaboration with Dr Michael Phelan and an expert steering group comprising of mental health professionals, service user representatives and stakeholders from

**General health and lifestyle**

**Please circle either YES or NO and tick the box if needs have been identified.**

**1.1 Do you have any diagnosed physical illness or condition?** Yes / No

If **yes**, please give details: (include both minor and serious conditions)

**If yes, are you receiving treatment for these?** Yes / No

If **yes**, please give details:

**List any conditions not currently receiving treatment.**

**1.2 Do you have a disability or impairment?** Yes / No

If **yes**, please give details:

**1.3 Have any of your immediate family or deceased relatives (parents, siblings)**

**had any of the following conditions?**

 Heart disease  Stroke  Cancer  Diabetes

 Family history of any other illness / condition, please specify and give details:

**1.4 Please list all medications you are currently using.**

(Include psychiatric and non-psychiatric medications, creams, inhalers, complementary treatments and any other remedies)

If you do not know the names of your medication, indicate this in the table below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Name of medication** | **Dose** | **Frequency** | **Date commenced** |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| 6 |  |  |  |  |

**Do you have any problems with any of these medications (e.g. side effects)?** Yes / No

If **yes**, please give details:

**Do you need information about any of the medications you are currently taking?** Yes / No

If **yes**, please give details:

 need identified and action required

 need identified and action required

**1.5 Do you think you eat a healthy diet?** Yes / No

(**prompts:** regular meals, fruit and vegetables, how often eat takeaways) Can you give examples of what you eat on a typical day?

**1.6 Do you take part in any physical activity or exercise?** Yes / No

(including walking, cycling, gardening etc.) If **yes**, what do you do?

How often do you do this?

**1.7 Do you smoke cigarettes or tobacco?** Yes / No

If **yes**, how much do you smoke per day?

If **no**, have you smoked in the past? Yes / No

If **yes**, please give details:

|  |  |  |
| --- | --- | --- |
|  | **Have you tried to stop smoking in the past?** | Yes / No |
| **Do you want to stop smoking?**If **yes**, is there any sort of help that you would like with this? | Yes / NoYes / No |
| **1.8** | **Do you drink alcohol?**If **yes**, what and how much do you drink? | Yes / No |

**Are you aware of the recommended maximum units of alcohol per week?** Yes / No

**1.9 Do you use recreational or non-prescription drugs (e.g. cannabis)?** Yes / No

If **yes**, what do you use and how often do you use them?

|  |  |  |
| --- | --- | --- |
| **1.10** | **Are you aware of the risks of sexually transmitted infection?**If **no**, would you like more information on this? | Yes / NoYes / No |
|  | **Would you like further information on any other sexual health issue?**(**prompts:** pregnancy, contraception, impotence etc.) | Yes / No |

**1.11 Looking back over the questions in this section do you have any concerns**

**about any of these issues or need any further information?** Yes / No

If **yes**, please give details:

**Symptoms checklist**

This section is for you to describe any current physical symptoms you are experiencing. Please give as much detail as possible in this section.

**2.1 In Table A below, tick any of these symptoms experienced.**

|  |  |
| --- | --- |
|  | Tick |
| Increased thirst |  |
| Increased or frequent urination |  |
| Breathlessness |  |
| Weight gain (unexpected) |  |
| Weight loss (unexpected) |  |
| Fits / blackouts |  |
| Constipation |  |
| Sexual dysfunction |  |
| Chest pain |  |

Please give details:

 need identified and action required

2.2 On each body figure please use numbers to indicate any areas where you experience current

or regular pain, discomfort or difficulties in your body.

Please include issues such as skin, dental, ear problems or incontinence.

Place a number in each area of difficulty on the body and then use **Table B** to explain further details about it. For example, ‘1’ placed over the chest area might indicate:

**Problem** - chest pain, **Frequency** - when exercising, **Impact** - prevents me from exercising.

**Table B**

**For other symptoms marked on body outline, note frequency and severity in the table below:**

 need identified and action required

|  |  |  |  |
| --- | --- | --- | --- |
| **Number** | **Problem** | **Frequency** | **Impact** |
| Example: 1 | Chest pain | When exercising | Prevents me from exercising |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Screening checks**

This section should be used to highlight areas that may require investigation and alert you to the need for checks that may be overdue.

**3.1 General health checks**

|  |  |  |
| --- | --- | --- |
|  | Date /timing | Any other details:e.g. reason for visit / results of test |
| When did you last visit your GPor practice nurse? |  |  |
| When did you last visit your dentist? |  |  |
| When did you last have your eyes tested? |  |  |
| When did you last have a blood test? |  |  |
| Have you had an ECG? Yes / No |  |  |
| Have you attended a yearly health check at your GP ? |  |  |

**3.2 Gender specific checks**

**A: Checks for women**

|  |  |  |
| --- | --- | --- |
|  | Date / timing | Any other details |
| When did you last have a cervical smear test? |  |  |
| When did you last have a menstrual period? |  |  |
| How often do you have your period? |  |  |
|  Do you examine your breasts? |  |  |
| When did you last have a mammogram(for women aged 50+)? |  |  |

**B: Checks for men**

|  |  |  |
| --- | --- | --- |
|  | Date / timing | Any other details |
| How often do you examine your testicles? |  |  |

**3.3 Please record the following information if possible:**

**Height** m/cm **Weight** kg **Calculate BMI Waist measurement** cm **Blood Pressure Urinalysis**

**3.4 Any other issues**

Are there any other issues we have not covered that you are concerned about? Yes / No

If **yes**, please give details:

 need identified and action required

**Your action plan**

In this table indicate any health needs that have been identified and what actions are to be taken.

**Name Today’s date**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health need identified | What action is to be taken? | By whom? | When is the action to be taken? | Followed up when and by who? | Any other comments |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Final questions**

**Are you satisfied with what we have agreed?** Yes / No

If **no**, please give details:

**Is there anything you are worried about as a result of this questionnaire?** Yes / No

If **yes**, please give details:

**Do you need any extra support at this time to help you with the**

**next step(s) we have identified?** Yes / No

If **yes**, please give details:

 need identified and action required



**Leading the way to a better quality of life for everyone affected by severe mental illness**

For further information

on Rethink Mental Illness

Phone 0845 456 0455

Email info@rethink.org

[**www.rethink.org**](http://www.rethink.org/)

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