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The PHC: a physical health check for mental health service users

PHC (Physical Health Check)

It is recommended that prior to completing the PHC with service users 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.

Service user's name _____

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 in collaboration with Dr Michael Phelan and an expert steering group comprising of mental health professionals, service user representatives and stakeholders from a number of special interest groups.

General health and lifestyle

✓ need identified and action required

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:

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? Yes / No
If **yes**, is there any sort of help that you would like with this? Yes / No

1.8 Do you drink alcohol? Yes / No
If **yes**, what and how much do you drink?

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? Yes / No
If **no**, would you like more information on this? Yes / No

Would you like further information on any other sexual health issue? Yes / No
(**prompts:** pregnancy, contraception, impotence etc.)

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	

✓ need identified and action required ☐

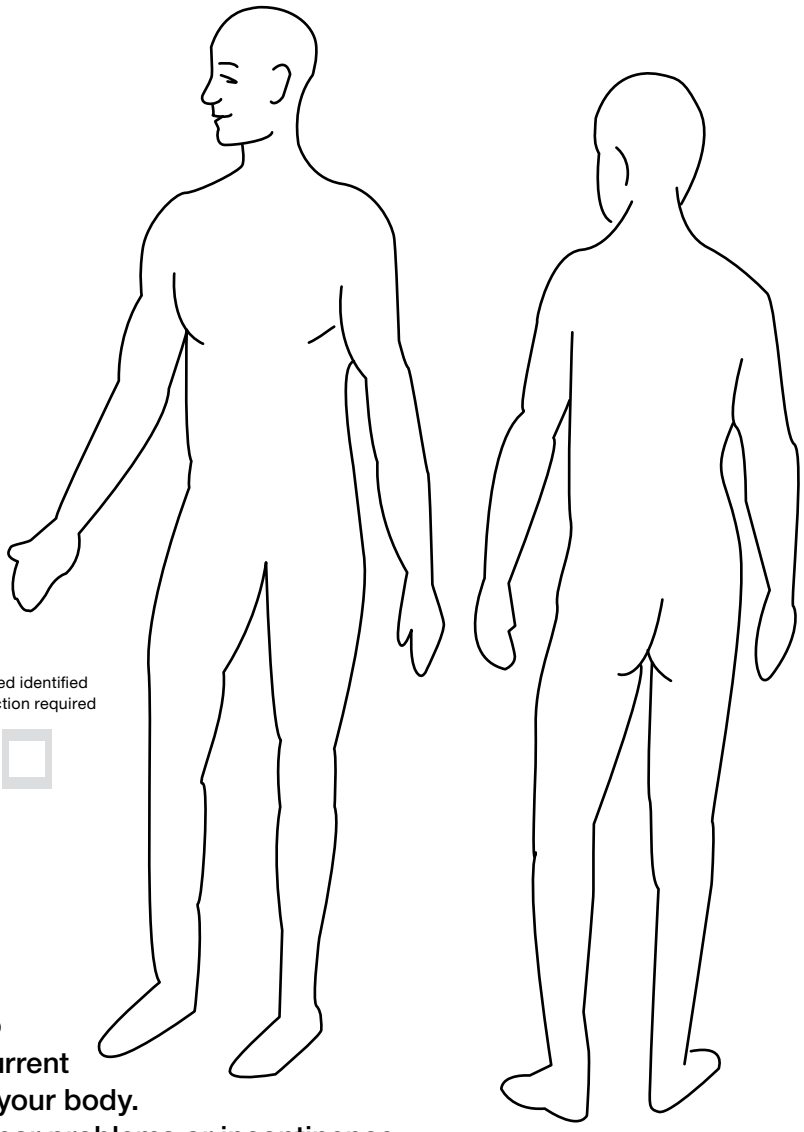
Please give details:

_____

_____

_____

_____



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.

✓ need identified and action required

3.1 General health checks

	Date / timing	Any other details: e.g. reason for visit / results of test
When did you last visit your GP or 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		

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?		
How often 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?		
When did you have your last prostate screening test (for men aged 50+)?		

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:

_____

_____

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

✓ need identified and action required

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:

_____

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Working together to help everyone affected by severe mental illness recover a better quality of life

FundRaising Standards Board

MINDFUL EMPLOYER

POSITIVE ABOUT DISABLED PEOPLE

INVESTOR IN PEOPLE

The PHC Project is sponsored by
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