



PROBLEM LIST

NAME OF YOUTH: _____

DATE OF BIRTH: _____ DJJID#: _____

Date of Most Recent Comprehensive Physical Assessment _____

ALLERGIES:

Original Medical Classification

Revised Classification

- Grade 1
- Grade 2
- Grade 3
- Grade 4
- Grade 5

-
-
-
-
-

Date of Original Classification: _____

Date of Revision: _____

PHYSICAL HEALTH

NO	Date Identified	Active Problem	Health Care Professional/Facility	Date Resolved
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				





PROBLEM LIST (continued)

NAME OF YOUTH: _____

DENTAL HEALTH

NO	Date Identified	Active Problem	Health Care Professional/Facility	Date Resolved
1.				
2.				
3.				
4.				
5.				

MENTAL HEALTH

NO	Date Identified	Active Problem	Health Care Professional/Facility	Date Resolved
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

