MSSP Initial Health Assessment Summary (Optional)

Participant Name _____ MSSP #_____

Assessment Date _____ Telephone_____ Staff Code _____

***Summarize current circumstances and needs*:**

Participant Description:

Medical History / Review of Systems / Vital Signs / Diagnoses:

Medical Care / Medications:

Nutrition / Health Habits:

Print Staff Name: _____
Staff Signature/Title: _____