Palm Beach Behavioral Center Inc
🏢 6295 Lake Worth Rd, Suite #40, Greenacres, FL 33463
✉ General Email: behavioralcenterpb@gmail.com – 📄 Documents Email: hr@behavioralcenterpb.com
🌐 Website: behavioralcenterpb.com - 📞 Phone: (561) 508-6150 – 📠 Fax: (561) 431-2208

PHYSICAL EXAMINATION FORM

Employee Name: _____

Date of Birth: _____ **Date of Exam:** _____

Vital Signs and Measurements

Measurement	Value	Measurement	Value	Measurement	Value
Weight		Pulse		Temp	
Height		Resp		B/P	
BMI		Oxygen Sat (%)		Vision (L/R)	

Medical History (Check all that apply)

Condition	Yes	No	Condition	Yes	No
High Blood Pressure	☐	☐	Diabetes	☐	☐
Heart Disease	☐	☐	Seizure Disorder	☐	☐
Respiratory Issues (Asthma, COPD)	☐	☐	Tuberculosis	☐	☐
Kidney Disease	☐	☐	Hepatitis	☐	☐
Mental Health Conditions	☐	☐	History of Substance Abuse	☐	☐
Allergies (Food, Medications)	☐	☐	Skin Conditions	☐	☐

If "Yes" to any, please provide details:

_____

_____

Clinical Evaluation (Please Check)

Clinical Area	Normal	Abnormal	Comments
Head, Eyes, Ears, Nose, Throat	☐	☐	
Vision & Hearing	☐	☐	
Lungs & Chest (Include Breast)	☐	☐	
Heart (Rate, Rhythm, Murmurs)	☐	☐	
Abdomen (Tenderness, Masses)	☐	☐	
Extremities (Strength, Mobility)	☐	☐	
Neurological (Reflexes, Coordination)	☐	☐	

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Clinical Area	Normal	Abnormal	Comments
Skin (Lesions, Rashes)	☐	☐	
Mental Status (Orientation, Mood)	☐	☐	

Tests Performed

Test	Date Performed	Results
PPD		
Chest X-rays (if PPD Positive)		
Quantiferon Lab (Blood Work)		

Physician Comments & Work Restrictions

☐ No restrictions
☐ Yes, the following restrictions apply:

_____

_____

Based upon this physical examination, I certify that the above-named individual is in good general health, free from communicable diseases, and is mentally and physically capable of performing job duties:

☐ Without restrictions
☐ With the following restrictions: _____

Health Care Provider Information

Physician Name: _____ **Signature:** _____

Medical License Number: _____ **Date:** _____