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	Exam/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.				

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