EPINET
Early Psychosis Intervention Network

Client ID # ____________________ Date of Administration: ____________________

HEALTH

CLINICIAN-COMPLETED AND RECORD REVIEW

1. **Client's height:** ______ ft ______ in
   ☐ Not collected

2. **Client's weight:** ______ lbs ______oz
   ☐ Not collected

3. **Client's BP:** Systolic (upper number): _______ Diastolic (lower number): _________
   ☐ Not collected

4. **[OPTIONAL] Client's Total Cholesterol (mg/dl):** ________
   ☐ Not collected

5. **[OPTIONAL] Client's LDL cholesterol (mg/dl):** __________
   ☐ Not collected

6. **[OPTIONAL] Client's HDL cholesterol (mg/dl):** __________
   ☐ Not collected

7. **[OPTIONAL] Client's Triglycerides (mg/dl):** ____________
   ☐ Not collected

8. **[OPTIONAL] Client's fasting glucose (mg/dl):** __________
   ○ Client did not fast
   ○ Not collected

9. **[OPTIONAL] Client's fasting insulin (uU/ml):** __________
   ○ Client did not fast
   ○ Not collected

10. **[OPTIONAL] Client's hemoglobin A_{1c} (HbA_{1c}):** __________
    ☐ Not collected