DEER LODGE CENTRE

Making lives better

Name: _____

Preferred phone #: _____ OK to leave message? ☐ Yes ☐ No

Date of Birth: _____ Place of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Common-law ☐ Widowed

Partner's Name: _____ Years Together _____

Children: (names/ages): _____

_____

First language: ☐ English ☐ French ☐ Other _____

Health Care Information

List current health care professionals (medical doctor, psychologist, psychiatrist, etc.)

Name	Address	Phone #

Have you ever experienced the following:

a) Head Injury ( ) Yes ( ) No
b) Loss of consciousness ( ) Yes ( ) No
c) Seizure ( ) Yes ( ) No

I am concerned about my physical pain: ( ) Yes ( ) No (even if no, please answer next question)

What number best describes your <u>pain on average</u> in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

Do you have any of the following long-term conditions that have been diagnosed by a health professional? (Please <u>circle:</u> Y= YES, N = NO)

Heart Disease	Y	N	Arthritis or Rheumatism	Y	N
Effects of stroke	Y	N	Back problems excluding arthritis	Y	N
Asthma	Y	N	High blood pressure	Y	N
Sinusitis	Y	N	Migraine headaches	Y	N
Diabetes	Y	N	Chronic bronchitis or Emphysema	Y	N
Thyroid condition	Y	N	A bowel disorder or Crohn's disease or colitis	Y	N
Epilepsy	Y	N	Stomach or intestinal ulcers	Y	N
Urinary Incontinence	Y	N	Alzheimer's Disease or other dementia	Y	N
Cancer	Y	N			

If YES to Cancer, specify type: _____

List any known allergies: _____

Date of Last Physical Exam: _____

Are you presently taking any prescription medications, over the counter medications or herbal remedies? ☐ **Yes** ☐ **No**

If yes, please list them (or if you prefer, provide a pharmacy print out):

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Do you use medical marijuana (cannabis)?
(Please circle) Yes No

Do you use non-medical marijuana?
(Please circle) Yes No

If yes to either of the above, please specify quantity (e.g. 2 grams/day) _____

Has anyone in your family had one of the following emotional problems or mental illnesses?

(If yes – please specify the relationship of that person to you)

Depression	Yes _____	No _____	_____
Manic depression (Bipolar disorder)	Yes _____	No _____	_____
Schizophrenia	Yes _____	No _____	_____
Alcoholism	Yes _____	No _____	_____
Anxiety Problems	Yes _____	No _____	_____
Completed suicide	Yes _____	No _____	_____
Drug Abuse	Yes _____	No _____	_____

Military/R.C.M.P. History (as applicable)

Year enlisted: _____ Location: _____

Current / Retirement Rank: _____ ☐Air Force ☐Army ☐Navy ☐ RCMP

Military Trades Held / RCMP Postings Dates (e.g., infantry 1993-1996; Cross Lake 2005-2007)

_____

_____

_____

_____

Deployment and Secondment History Dates (e.g., Bosnia 2002)

_____

_____

_____

_____

Years in the Regular Force _____ Years in the Reserve Force _____

Release/ Retirement from CF/ RCMP (check ONE)

☐ Yes, already released Date:_____ Type (e.g., medical, voluntary, etc.)_____

☐ Planned release Date:_____ Type (e.g., medical, voluntary, etc.)_____

☐ Still Serving with no concrete release/ retirement plans ☐ Unsure

Study and Work History:

Which statement describes your current employment situation?

☐	☐	☐	☐	☐	☐
At work full-time	At work part-time	On leave of absence	Unemployed	Retired	Student

Are you currently on a category? (TCAT, PCAT) _____

Please indicate the highest level of education completed:
(e.g., grade 8, grade 12, college degree, university degree, etc.):

_____

If you are currently working, please state your occupation:

_____

How long have you been in your current occupation? _____

Emergency contact: Name_____ Phone number_____

Manitoba Health Number: _____ (6 digits); PHIN_____ (9 digits)

(Note: Currently serving CF personnel may not have a Manitoba Health Card)

_____	_____	_____
Signature	**Date**	**Print Name**