DEER LODGE CENTRE

Making lives better

Name: _____

Mailing Address: _____

_____

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 _____

Reason for Referral:

What are the main issues, concerns or symptoms for which you were referred to the Operational Stress Injury Clinic?

_____

_____

Please state any know mental health diagnosis: _____

Health Care Information

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

Name	Address	Phone #

Do you have any of the following long-term conditions that have been diagnosed by a health professional? (Please **circle:** 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: _____

Please 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) _____

List previous treatment, if any, for medical and mental health issues.

Date	Condition	Treatment	Health Care Professional

Have you ever experienced:

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 3 questions.

What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

What number best describes how, during the past week, the pain has interfered with your enjoyment of Life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

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.).

_____

Position Held Dates (e.g. landscaping 1999-present)

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

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