Project New Hope Canada Inc.
Family Retreat Medical Form

All information will be kept confidential before, during and after the Retreat

Participant Name _____

Daytime Phone (_____)_____Evening Phone (_____)_____

Doctor's Name _____ Doctor's Phone _____

Manitoba Health Number _____

Other Insurance Policy _____

Registration Number _____

Emergency Contact Name _____ Relationship _____

Daytime Phone (_____)_____ Evening Phone (_____)_____

General Medical History

Do you currently have a history of:

1. Respiratory Problems Yes ____ No ____
2. Asthma Yes ____ No ____

If so, what triggers attack? Last episode? Any other pertinent information?

_____

3. Gastrointestinal disturbances Yes ____ No ____
4. Diabetes Yes ____ No ____
5. Blood disorders Yes ____ No ____

If so, what are the specifics?

_____

6. Neurological problems Yes ____ No ____
7. Seizures Yes ____ No ____
8. Dizziness, fainting Yes ____ No ____
9. Migraines Yes ____ No ____

If so, describe frequency, date of last episode and severity.

_____

10. Disorders of urinary tract Yes ____ No ____
11. Hypertension Yes ____ No ____
12. Cardiac Problems Yes ____ No ____

If so, include specifics.

_____

Questions 13 and 14 are for female participants only.

13. Treatment for menstrual cramps Yes ____ No ____
14. Pregnant Yes ____ No ____

If so, include specifics.

_____

In the past three years do you have a history of:

15. Fractures Yes ____ No ____
16. Sprains Yes ____ No ____
17. Other joint or muscle injury Yes ____ No ____

If so, include specifics including injury location on body, when it occurred, was surgery required, special considerations.

_____

15. Food allergies Yes ____ No ____
16. Dietary restrictions Yes ____ No ____
17. Environmental Allergies Yes ____ No ____

If so, include allergies to food and food intolerances, specifics including triggers, reactions and treatment

_____

_____

Medications

18. Do you plan to take prescription or nonprescription medications during the program? Yes ____ No ____

If so please complete table. Attach separate sheet if necessary.

Medication	Dosage, Include amount and time taken	Side effects	Restrictions	For what condition

Personal History

Are you currently experiencing or in treatment or counselling for:

19. Substance abuse Yes ____ No ____
20. Eating disorder Yes ____ No ____
21. Anxiety disorder Yes ____ No ____
22. Depression Yes ____ No ____
23. ADD/ADHD Yes ____ No ____
24. Other _____ Yes ____ No ____

If so, include specifics including triggers, reactions and treatment

_____

_____

25. Date of last tetanus shot _____

By my signature, I attest all information on this form is complete, thorough and truthful.

Signature (of parent/guardian if under the age of 18) _____

Date _____