



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 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 #

Do you currently have any medical conditions (e.g., diabetes, asthma, seizure disorder)?
 No Yes If yes, please indicate the type of medical condition(s) below:

Do you have any allergies (drug/food/other)? _____

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

If yes, please list them:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Have you ever experienced:

a) Head Injury Yes No

b) Loss of consciousness Yes No

c) Seizure Yes No

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

Condition	Treatment	Health Care Professional

Military History

Year enlisted: _____ Location: _____

Military Trades Held Dates (e.g., infantry 1993-1996)

Deployment History Dates (e.g. Bosnia 2002)

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

Study and Work History:

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

Please list employment outside of military service (past and current):

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

Family of Origin History:

Mother's Name: _____ Still Living: Yes No

Father's Name: _____ Still Living: Yes No

Please list the names and ages of all your brothers and sisters:

Name	Age	Biological/step/or half-sibling

Has anyone in your family ever been diagnosed with or treated for a mental health concern?

Yes No

If yes, please indicate their relationship to you (e.g. mother, father, brother, grandmother, etc.) and what their mental health difficulty was (e.g. depression, anxiety, etc.).

Their relationship to me	Mental Health Concern

Signature

Date

Print Name