



LONE EAGLE HEALING CENTRE

491 GRAHAM ROAD, ELSIPOGTOG, NB, E4W 2T8

PHONE: 506 523 8244 FAX: 506 523 8242

MEDICAL FORM

Applicant's Name		Health Care Number	
10-Digit Treaty Number		Are you the applicant's regular physician?	

A Medical History: (Explain any "yes" responses.)

	Diagnosed		Tested		Comments
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Chronic bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heart problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Gastrointestinal problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Pancreatic problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Kidney or urinary problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diabetes / hyperglycemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Chronic Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Eating disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sleep disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Withdrawal symptoms, seizures, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Mood disorders (e.g., major depressive disorder)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Psychotic disorders (e.g., schizophrenia)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Personality Disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Liver Problems: Hepatitis B & C	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Sexually Transmitted Infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Medical Confirmation of pregnancy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is all related testing complete?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Are there any special considerations regarding the pregnancy and pre-natal care we need to be aware of?

Current Blood Pressure:

Any other medical problems not listed:

Are there any specific problems that should be considered in the treatment of this applicant?

CURRENT MEDICATIONS
 Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. (Current computer printed attachment is acceptable.) Please note no mood-altering medications will be allowed in residential treatment unless prescribed and monitored by a psychiatrist for management of a mental illness.

Drug Name	Dose/Schedule	Length of Time Used	Consistent use?	Clinical Indication
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	

Is the client stabilized on medication? Yes No

If the past 6 months had the cleint been using the medication appropriately? Yes No

Physicians Signature/Stamp Information: DATE: