Confidential Medical Record

The New Warrior Training Adventure includes challenging experiences that may involve strong emotional and physical release. This training may not be appropriate for men with some major medical or emotional problems. In order to acquaint our staff with your medical needs, we require that you complete this Confidential Medical Record. Completion of this form and your participation on the NWTA do not, however, constitute medical or psychological screening or any approval by us of your physical, mental or emotional condition for the NWTA. We strongly recommend that you have a medical exam prior to the training and that you review your intention to attend the NWTA with your physician, therapist, or psychiatrist. If you become ill or are injured on the weekend we may share this information with medical personnel. Otherwise, all information will be kept strictly confidential.

Please complete every item in every section. Mark N/A if any section is not applicable. Please keep a copy for your records.

General Information

Name		Who most influenced your decision to attend?	
Address		Emergency Contact	
Home Phone		Home Phone	
Cell Phone		Cell Phone	
Fax		Address	
Birth Date			
Occupation		Do you have health insurance? Yes ☐ No ☐	
Address		Insurance Company	
		Policy Number	
Physician		Insurance Phone	
Physician Phone		Insurance Address	

Do you have Canadian government health care? Yes ☐ No ☐

Province under which you are insured: _____ Personal Health Care Number: _____

Do you have additional health insurance? Yes ☐ No ☐

For MKP Review Use Only

- Date Reviewed: _____
- Did you make any phone calls for additional information? Yes ☐ No ☐
- Additional Information and Sources: _____

Reviewer's Name: _____	**Reviewer's Signature**	**Date:** _____
MHRT Name: _____	**MHRT Signature**	**Date:** _____

Name: _____

Medical History

Do you have, or have you had, any of the following conditions or symptoms? Please specify **Yes** or **No** for each condition.

	Yes	No		Yes	No		Yes	No
1. Heart disease of any kind	☐	☐	20. Arthritis	☐	☐	39. Eating disorder	☐	☐
2. Heart attack	☐	☐	21. Joint problems	☐	☐	40. Psychiatric/emotional problems	☐	☐
3. Heart murmur	☐	☐	22. Broken bones	☐	☐	41. Difficulty urinating	☐	☐
4. Irregular heartbeat	☐	☐	23. Neck or back problems	☐	☐	42. Kidney problems	☐	☐
5. Heart palpitations	☐	☐	24. Diabetes	☐	☐	43. Bleeding disorder	☐	☐
6. Chest pain or pressure	☐	☐	25. Hypoglycemia	☐	☐	44. Blood disorder or anemia	☐	☐
7. Circulation problems	☐	☐	26. Thyroid problems	☐	☐	45. Sickle cell trait or disease	☐	☐
8. High blood pressure	☐	☐	27. Unexplained weight loss	☐	☐	46. HIV or AIDS	☐	☐
9. Unexplained sweating	☐	☐	28. Obesity	☐	☐	47. Medical equipment or devices	☐	☐
10. Shortness of breath	☐	☐	29. Endocrine/gland problems	☐	☐	48. Skin problems	☐	☐
11. Asthma	☐	☐	30. Vision impairment	☐	☐	49. Special dietary needs	☐	☐
12. Chronic cough	☐	☐	31. Cancer	☐	☐	50. Special physical requirements	☐	☐
13. Tuberculosis (TB)	☐	☐	32. Headaches	☐	☐	51. Bipolar Disorder	☐	☐
14. Frequent lung infections	☐	☐	33. Seizure disorder	☐	☐	52. Mood Disorder	☐	☐
15. Ulcer	☐	☐	34. Seizure within the last year	☐	☐	53. Post Traumatic Stress Disorder	☐	☐
16. Heartburn	☐	☐	35. Significant head injury	☐	☐	54. Major Depression	☐	☐
17. Intestinal problems	☐	☐	36. Frequent dizziness	☐	☐	55. Other	☐	☐
18. Active hepatitis	☐	☐	37. Frequent fainting	☐	☐			
19. History of Hepatitis	☐	☐	38. Learning disorder	☐	☐			

Have you ever been hospitalized? Yes ☐ No ☐ Height: _____ Weight: _____ Age: _____

If you answered* Yes *to any of the items above, please explain on page 4.

Medications

Are you taking **any** medications (prescription or nonprescription) Yes ☐ No ☐

If* Yes*, please list below.

Medication	How Much/How Often	For	Current Side Effects

Medical Allergies

Do you have any medical allergies? Yes ☐ No ☐

If* Yes*, please list below.

Medication	Reaction

Name: _____

PSYCHOSOCIAL HISTORY

Check the* Yes *or* No *box for each question below. If you answer* Yes *to any questions, please provide details on page 4.

A. **YES** ☐ **NO** ☐ Have you been in psychotherapy, counseling, rehab, or a 12-step program; or been seen by a psychiatrist, psychologist, social worker or counselor in the past two years?

B. **YES** ☐ **NO** ☐ Are you currently in counseling, therapy or mental health treatment?

Whether or not you answered* Yes *to A or B, please check all which apply to you:

- ☐ mood, depression, sadness, grief
- ☐ anxiety, panic
- ☐ negative thinking, poor judgment or poor behavior
- ☐ controlling impulses such as anger, spending, eating, or sex
- ☐ alcohol/drugs, or trouble controlling behavior involving gambling, porn, internet, or sex
- ☐ self-harm, destructive behavior, suicidal thoughts or attempts
- ☐ career or academic problems
- ☐ divorce, end of partnership, or family-related problems
- ☐ trouble sleeping
- ☐ Other: _____

Primary Counselor, Psychologist, or Psychiatrist: _____

Address: _____

Phone: **Email:**

C. **YES** ☐ **NO** ☐ Have you ever been hospitalized for a psychiatric or emotional condition?
If* Yes*, list all diagnoses, dates, and length of hospitalization on Page 4.

D. **YES** ☐ **NO** ☐ In the past few months, have you been thinking about harming yourself, ending your life, or making plans to do either?

E. **YES** ☐ **NO** ☐ Have you ever made an attempt to end your life?
If **Yes**, how many times? _____ Age at time of attempt(s): _____

F. **YES** ☐ **NO** ☐ In the past few months, have you been thinking about harming, or ending the life of someone else, or made plans to do either?

G. Have you ever had periods when you:
- **YES** ☐ **NO** ☐ Were unusually irritable, or got into arguments or frequent conflict with others?
- **YES** ☐ **NO** ☐ Needed much more or less sleep or food than usual?
- **YES** ☐ **NO** ☐ Found yourself having unusual bursts of energy?
- **YES** ☐ **NO** ☐ Felt driven to take risks you normally wouldn't, or felt driven to engage in activities to avoid slowing down?
- **YES** ☐ **NO** ☐ Were so abnormally fatigued or drained that doing any task felt like a chore?
- **YES** ☐ **NO** ☐ Found yourself experiencing thoughts or perceptions that you think nobody else could experience?

H. Have you ever experienced significant trauma resulting in:
- **YES** ☐ **NO** ☐ Flashbacks, or reliving the event; or repeated recollections or dreams of the event?
- **YES** ☐ **NO** ☐ A feeling of going numb or blank in response to reminders of the experience or of something like it?
- **YES** ☐ **NO** ☐ Avoiding thoughts, feelings, conversations, or activities that remind you of the trauma?

Are you a veteran or presently enlisted in the Armed Forces?

I.
- **YES** ☐ **NO** ☐ If so, in which conflict and when _____
- **YES** ☐ **NO** ☐ Were you ever involved in, or did you witness combat, torture or other violence?

J. **YES** ☐ **NO** ☐ Do you smoke or chew tobacco?
If **Yes**, last time used: _____ Times per day: _____

K. **YES** ☐ **NO** ☐ Do you drink alcohol?
If **Yes**, last time used: _____ Amount per day or week: _____

L. **YES** ☐ **NO** ☐ Do you use recreational drugs?
If **Yes**, last time used: _____ If so, which ones and how often: _____

M. **YES** ☐ **NO** ☐ In the last year, have you ever drunk alcohol or used drugs more than you meant to?

N. **YES** ☐ **NO** ☐ Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Name: _____

Detailed Responses

If you answered* Yes *to any of the questions on Page 2 or 3, explain below. Include the following:

- What specific symptoms are occurring
- How often symptoms/conditions occur
- How long symptoms/conditions last
- How you care for symptoms/conditions
- How symptoms/conditions restrict your activity
- When treatment was initiated
- Date(s) of occurrence
- Any other information we should know

Number/Letter	Detailed Response

Name: _____

Signature Required

The information provided on pages 1 to 4 above is a complete and accurate statement of the physical and psychological factors that may affect my participation in the New Warrior Training Adventure. I realize that failure to disclose such information could result in serious harm to me or to fellow participants. I understand that the NWTA is not a substitute for traditional recovery programs, and that men in recovery are encouraged to continue or renew their participation in recovery programs including close communication with their sponsors.

I agree to notify The ManKind Project should there be any changes in my health status. I authorize The ManKind Project to release this information to medical personnel if necessary in an emergency. I understand that The ManKind Project reserves the right to refuse participation to any man for medical or psychological reasons.

_____ _____

Signature ***Date***