HOPE FARM

Hope Farm Healing Centre
Medical Assessment

Applicant's name: _____Date Form Completed _____

Applicants must have this completed by a physician and sign the bottom of this form.
NB: The cost of this health questionnaire is the responsibility of the applicant.

	History of:	yes	no	Please explain 'yes' responses
1	Allergies			
2	Central Nervous System			
3	Epilepsy, Withdrawal Seizures			
4	Pain: Acute, Chronic			
5	Mental Health Disorders			
6	Suicidal Thoughts			
7	Attempted Suicides			
8	Drug or Alcohol Abuse or Addiction			
9	Eating Disorder			
10	Sleeping Disorder			
11	Respiratory System Disorders			
12	Circulatory System Disorder BP__/__			
13	Gastrointestinal Disorder			
14	Hepatic Disorder (*i.e.* HCV, HBV, Hepatitis)			
15	Pancreatic Disorder (*i.e.,* Diabetes, Pancreatitis)			
16	Urinary System Disorder			
18	STDs, HIV+, AIDS			
19	Other Health Problems or Recent Hospitalisation			
	TB Screening: Symptoms and History			
1	Presence of a cough lasting more than two weeks			
2	Weight loss___#lbs___length of time			
3	Night sweats			
4	Fever			
5	Fatigue			
6	Haemoptysis (Blood in Sputum)			
7	Recent or past exposure to TB			
8	Previous active TB and treatment			
9	Previous significant Mantoux results or Chest X-ray results			

10	Extensive travel (or birth) in a country with a high incidence of TB			
11	Other risk factors for infection (Aboriginal, elderly, homeless, health care worker)			
12	Poor general health status and risk factors for progression of disease			
	Actions			
	Further TB screening or assessment required (if 'yes' please fax results to Hope Farm Healing Centre 250.748.4495)			

Current Medications (Including prn meds and OTC)		
Medication Name	Prescribed By	Length of Time Used

Are there any special problems (physical or psychological) that should be considered in the treatment of this applicant (e.g., difficulty with stairs or anxiety attacks, &c)

Please attach:

- ☐ Relevant medical, laboratory, or radiological reports
- ☐ Recent psychological assessments or evaluations

Are you the applicant's regular physician? **Yes** **No**

Physician _____Signature _____
Mailing Address _____ Postal Code_____
Phone _____ Fax _____

I hereby authorise the above-named physician to release to the Mustard Seed Street Church medical information which is required to assess my suitability for acceptance and admittance to Hope Farm Healing Centre.

Applicant's Signature _____ Date _____