CONFIDENTIAL HEALTH FORM

To help us know the needs of the group, please answer the following questions. We will **not** share this information unless there is a medical need.

Please print your name: ____

Make a check mark if you have any of the following health conditions:

☐ Alcoholism
In recovery how long?
____

☐ Allergies
☐ Asthma
☐ Cancer
☐ Diabetes

☐ Drug addiction
In recovery how long?
____

☐ Heart disease
☐ High blood pressure
☐ Kidney disease
☐ Liver disease
☐ Mental illness
  ☐ Anxiety
  ☐ Depression

If other than anxiety or depression, please specify.
____

☐ Seizures
☐ Ulcers
☐ Other. Please specify.
____
____
____

Are you on a special diet? ☐ No ☐ Yes If yes, what? __________________________

Do you take prescription medication? ☐ No ☐ Yes If yes, please list here & on back.

______________________________ ______________________________

______________________________ ______________________________

Do you smoke? ☐ Yes ☐ No NOTE: The Center of Renewal is a nonsmoking facility. Use of alcohol or drugs is prohibited.

Do you have any health needs that would be important for our staff to know about?

____

In a medical emergency, what doctor should we call for you?

Name ________________________________ Phone # ________________________

Send your completed health form and application form by (application deadine) to:
Women's Respite Program ✹ 1301 Ferry Ave. ✹ Niagara Falls, NY 14301

If you have questions, please call 716/893-0931.