Butler Creek
LIFESTYLE CENTER

Guest Admission Form

Guest's Name (Last, First, MI): _____

Guest's Phone Number: _____ Alternate Phone Number: _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F

Marital Status: _____ Name of Partner/Spouse: _____

Occupation _____ Religion _____ Nationality _____

IN CASE OF AN EMERGENCY

Emergency Contact: _____ Relationship to Guest: _____

Address: _____ Phone number: _____

Due to rising Covid-19 cases we are ask our Guests to take a Covid test at least 5 days prior to their arrival. Results can be sent by email to: admin@butlercreekhealthcenter.org

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Medical History

Height: _____ Weight: _____ Temperature: _____

BP: _____ Pulse: _____ Respiration: _____

Physical Disabilities:

_____

_____

Medical Information

Please list any **Medications** you are currently taking, including prescribed or over the counter, vitamins minerals, supplements, hormones etc. (use the back of page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

If **you** or a **family member** has had any of the following, please circle and indicate which family member when applicable. (**C**: currently, R: recent history, **P**: past history)

	C	**R**	**P**		**C**	**R**	**P**
ADD/ADHD				Neurological Disease:			
Anemia							
Arthritis				Osteopenia/Osteoporosis			
Asthma				Muscle, back, joint pain			
Anxiety/Depression				Respiratory Disease			
Alcoholism				Skin Disease			
Diabetes (Type 1 or 2)				Stomach Distress/Disease			
Cancer, Type(s):				Stroke			
				Seizure Disorders			
Epilepsy				STD's:			
Factures				Osteopenia/Osteoporosis			
Gynecological Disease				Respiratory Disease			
Gastrointestinal Disease				Skin Disease			
Heart Disease				Respiratory Disease			
Hemorrhoids				Other:			
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Malaria							
Mumps							

Please list any **SURGERIES** you have had and include the month/year:

Mental History

Condition	**Date Diagnosed**	**Comments**
Depression		
Bi-polar		
Schizophrenia/Psychotic		
Other (Specify): (Panic Disorder; Obsessive-Compulsive Disorder)		

Suicide attempts: _____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ How long?____
Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? _____
Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____ When? _____

Addictions:

Drug	Age Started	Frequency	Attempts to Stop

Institutionalized: _____

Do you **exercise**? _____ What activities do you do, and how often in 1 week? _____
_____
Are you on any special **diet**? _____ If so, what? _____
What time and type of foods/breakfast? _____
Favorite Foods _____
Do you consume any **caffeinated** products? _____ If so, what and how much per day? _____
Have you recently noticed an increase in sadness or gloominess? _____
Have you lost interest in enjoyable activities? _____

Sleep Pattern
How many hours or sleep do you get/night? _____
What time do you usually go to bed? _____

Religious Background
Do you attend church? _____
When was the last time you attended? _____
Do you have any spiritual interest? _____

Comments:
_____
_____
_____