



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?

Drug addiction
In recovery how long?

If other than anxiety or depression,
please specify.

Allergies

Heart disease

Seizures

Asthma

High blood pressure

Ulcers

Cancer

Kidney disease

Other. Please specify.

Diabetes

Liver disease

Mental illness

Anxiety

Depression

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 March 23, 2017 to:

Women's Respite Program • 1301 Ferry Ave. • Niagara Falls, NY 14301

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