Last Name:

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		Emergency Contact	
Address		Relationship	
Home Phone		Home Phone	
Mobile Phone		Mobile Phone	
Email Address		Address	
Birth Date			
Occupation		Do you have health insurance? Yes ☐ No ☐	
Work Address		Insurance Company	
		Policy Number	
Physician		Insurance Phone	
Physician Phone		Insurance Address	

I am ☐ a participant, ☐ staff or leader, ☐ MOS

For MKP USA Review Use Only

- Center: _____ Date of Training: _____
- 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:**

Last 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	☐	☐	19. History of Hepatitis	☐	☐	37. Frequent fainting	☐	☐
2. Heart attack	☐	☐	20. Arthritis	☐	☐	38. Learning disorder	☐	☐
3. Heart murmur	☐	☐	21. Joint problems	☐	☐	39. Eating disorder	☐	☐
4. Irregular heartbeat	☐	☐	22. Broken bones	☐	☐	40. Difficulty urinating	☐	☐
5. Heart palpitations	☐	☐	23. Neck or back problems	☐	☐	41. Kidney problems	☐	☐
6. Chest pain or pressure	☐	☐	24. Diabetes	☐	☐	42. Bleeding disorder	☐	☐
7. Circulation problems	☐	☐	25. Hypoglycemia	☐	☐	43. Blood disorder or anemia	☐	☐
8. High blood pressure	☐	☐	26. Thyroid problems	☐	☐	44. Sickle cell trait or disease	☐	☐
9. Unexplained sweating	☐	☐	27. Unexplained weight loss	☐	☐	45. HIV or AIDS	☐	☐
10. Shortness of breath	☐	☐	28. Obesity	☐	☐	46. Medical equipment or devices	☐	☐
11. Asthma	☐	☐	29. Endocrine/gland problems	☐	☐	47. Skin problems	☐	☐
12. Chronic cough	☐	☐	30. Vision impairment	☐	☐	48. Special dietary needs	☐	☐
13. Tuberculosis (TB)	☐	☐	31. Cancer	☐	☐	49. Special physical requirements	☐	☐
14. Frequent lung infections	☐	☐	32. Headaches	☐	☐	50. Bipolar Disorder	☐	☐
15. Ulcer	☐	☐	33. Seizure disorder	☐	☐	51. Mood Disorder	☐	☐
16. Heartburn	☐	☐	34. Seizure within the last year	☐	☐	52. Post-Traumatic Stress Disorder	☐	☐
17. Intestinal problems	☐	☐	35. Significant head injury	☐	☐	53. Major Depression	☐	☐
18. Active hepatitis	☐	☐	36. Frequent dizziness	☐	☐	54. Other	☐	☐

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

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 ☐ Have you been in counseling, therapy or mental health treatment?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

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. Yes ☐ No ☐ Are you now or have you ever been on a list of Registered Sex Offenders?
If Yes, in what jurisdiction?

H. Have you had periods when you:

Yes ☐ No ☐ Were unusually irritable, or got into arguments or frequent conflict with others?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Yes ☐ No ☐ Needed much more or less sleep or food than usual?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Yes ☐ No ☐ Found yourself having unusual bursts of energy?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Yes ☐ No ☐ Felt driven to take risks you normally wouldn't, or felt driven to engage in activities to avoid slowing down?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Yes ☐ No ☐ Were so abnormally fatigued or drained that doing any task felt like a chore?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Yes ☐ No ☐ Found yourself experiencing thoughts or perceptions that you think nobody else could experience?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

I. Have you ever experienced significant trauma resulting in:

Yes ☐ No ☐ Flashbacks, or reliving the event; or repeated recollections or dreams of the event?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Yes ☐ No ☐ A feeling of going numb or blank in response to reminders of the experience or of something like it?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Yes ☐ No ☐ Avoiding thoughts, feelings, conversations, or activities that remind you of the trauma?
If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

J.	Yes ☐	No ☐	Are you a veteran or presently enlisted in the Armed Forces?
	Yes ☐	No ☐	If so, were you ever involved in, or did you witness combat, torture or other violence?
			If so, in which conflict and when
K.	Yes ☐	No ☐	Do you smoke or chew tobacco?
			If Yes, last time used: Times per day:
L.	Yes ☐	No ☐	Do you drink alcohol?
			If Yes, last time used: Amount per day or week:
M.	Yes ☐	No ☐	Do you use recreational drugs?
			If Yes, last time used: *If Yes, list which ones & how often on page 4*
N.	Yes ☐	No ☐	In the last year, have you ever drunk alcohol or used drugs more than you meant to or felt you wanted or needed to cut down on your drinking or drug use?
O.	Yes ☐	No ☐	Have you made attempts to stop or reduce your alcohol or drug use, or been advised to do so?
P.	Yes ☐	No ☐	Does your drinking or drug use interfere or has it interfered with your social or occupational functioning? If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐
Q.	Yes ☐	No ☐	Are you now or have you been in a 12-step recovery program? *If Yes, list which ones on page 4* If yes, when? Currently ☐ In last 12 months ☐ Prior to 1 year ago ☐

Detailed Responses

If you answered* Yes *to any of the questions above, 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

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

_____	_____
Signature	***Date***