MUSHKEGOWUK HEALTH PRIMARY CARE
NEW PATIENT INTAKE FORM

A. CLIENT INFORMATION

Full name as it appears on your Health Card.
First Name: ______________________________ Middle Name(s): ______________________________

Last Name: ____

Preferred Name:

Date of Birth:	Age:

Do you Identify as: □ Male □ Female □ Other	Do you Identify as LGTBQ2+ ☐ Yes ☐ No ☐ Other ______________________________
Home Phone: ______________________________ Can we leave a message here? □ Yes □ No	Cell Phone: ______________________________ Can we leave a message here? □ Yes □ No

Email:	Preferred Method of Contact: □ Phone □ Mobile □ Email
Address:	PO Box #:

City:	Province:	Postal Code:

Do you have a status card? □ Yes □ No □ I don't know □ Not Applicable
Consent required for us to assist you if needed

First Nation:	Status #:
Ontario Health Card #:	Health Card Expiry Date:

B. EMERGENCY CONTACT / NEXT OF KIN / POWER OF ATTORNEY INFORMATION

To be contacted in the event of an emergency (ex: hospitalization)

Relationship to Client: ____
Emergency Contact: ____
Primary Contact Number: ____
Email: ____

IF COMPLETING THIS FORM FOR A MINOR OR ADULT DEPENDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Legal Guardian(s) Name: ________________________ Address: ________________________ Phone: ________________
Legal Guardian(s) Name: ________________________ Address: ________________________ Phone: ________________
Your relationship to the patient: ____

Individual resides with: ☐ Both parents ☐ Mother ☐ Father ☐ Caregiver ☐ Relative: __________________
☐ Group home ☐ Alone ☐ Other: ____

Is the child involved in any child and family services? □ Yes □ No

Name of service: ____
Name of worker: ____

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C. PHYSICIAN/NURSE PRACTIONER/SPECIALIST INFORMATION:

Do you have a physician, nurse practitioner or **specialist** that you are seeing? □ Yes □ No

NAME: _____
OFFICE:_____
PHONE NUMBER:_____

NAME:_____
OFFICE:_____
PHONE NUMBER:_____

D. CURRENT MEDICATION LIST (Including herbs, traditional medicine, and supplements)

Medication (include patches, creams, puffers, birth control & marijuana use)	**Dose**	**Frequency**	**Route (i.e. mouth, injection etc.)**

**Please remember to bring in ALL your medications you take when you have been contacted for an Intake appointment.

Who has been providing your prescriptions?

E. PHARMACY: Please provide name and contact information for your current and preferred pharmacy.

Pharmacy Name	Address	Phone	Fax

Pharmacy preference: ☐ Same as above

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F. MEDICAL HISTORY (Please check any you have been diagnosed with in the past)

Anemia		HIV/AIDS	
Anxiety		Irregular heartbeat	
Arthritis		Irritable bowel syndrome	
Asthma		Kidney Failure	
Bleeding disorders		Kidney stones	
Blood clots		Multiple sclerosis	
Cancer		Pacemaker/defibrillator	
Cataracts		Pancreatitis	
Chronic Obstructive Pulmonary Disease		Parkinson's disease	
Congestive heart failure		Polyps	
Crohn's disease		Rheumatoid arthritis	
Depression		Schizophrenia	
Diabetes □ type I □ type II		Seizures	
Difficulty hearing		Sleep apnea	
Diverticulitis		Stroke or paralysis	
G.E.R.D.		Substance or alcohol use/addiction	
Glaucoma		Suicide thoughts or attempt	
H. Pylori		Thyroid disease	
Heart Attack		Tuberculosis	
Heart murmur		Ulcerative colitis	
Hepatitis or Liver disease		Ulcers of stomach or intestine	
Hernia		Urinary tract infections	
High blood pressure		Other: _____	
High cholesterol		Other: _____	
History of falls		Other neurological problems: _____	
		Other mental illness:_____	

May use this area to add description if desired. _____

_____

_____

PAST SURGICAL HISTORY: Please list any prior surgeries

TYPE OF SURGERY	DATE	HOSPITAL

Allergies: Please list any allergies you have and your reaction (minor, major or life-threatening)

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FAMILY HISTORY: Is there a history of either **parents** or **siblings** having any of the following:		
Condition	**Name /Age of Family Member**	**Description of Illness**
Cancer □ Yes □ No		
Diabetes □ Yes □ No		
Stroke □ Yes □ No		
Heart Attack □ Yes □ No		
Depression □ Yes □ No		
Asthma □ Yes □ No		
Other		
Adopted/Unknown		

WOMENS HEALTH		
Date of last menstrual period:		□ Regular □ Irregular
Last pap test:		□ Normal □ Abnormal
Pregnancies:	# of Pregnancies: _____ # of Deliveries: _____ # of Miscarries: _____ # of Terminations: _____	
Mammogram:		□ Normal □ Abnormal
Other:		

MENS HEALTH		
Last PSA:		□ Normal □ Abnormal □Unknown
History of prostate cancer □ Yes □ No	Date:	Describe:
Other:		Describe:

PREVENTATIVE CARE	
When was the last time you had any blood work?	□ Unknown
Have you ever had a colonoscopy?	
Have you ever completed a take home Colon Cancer Stool Screening Test?	
Have you ever had a Bone Mineral Density Test?	

VACCINATION HISTORY	
VACCINE	**DATE**:
Influenza	
Covid-19	
HPV	
Hepatitis	
Tetanus	
Shingles	
Are your vaccines up to date? □ Yes □ No □ Unknown	
Other	

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G. SOCIAL HISTORY

Personal:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Common-Law
- ☐ Single parent
- ☐ Co-parenting

# of children? _____

Education Level:

- ☐ Elementary
- ☐ High School
- ☐ College/University
- ☐ No formal education

Did you attend residential school?

- ☐ Yes
- ☐ No

Employment:

- ☐ Full time
- ☐ Part time
- ☐ Casual
- ☐ Retired
- ☐ Currently unemployed
- ☐ Training / Other: _____

Occupation: _____

If employed, do you receive health benefits? ☐ Yes ☐ No

Tobacco Use:

- ☐ Never smoked
- ☐ Current smoker
- ☐ Ex-smoker
- ☐ Regular second-hand exposure

Form of tobacco/nicotine:

- ☐ Cigarettes (# _____ per day)
- ☐ Chewing tobacco (# _____ per day)
- ☐ Vaping (quantity _____ per day)

Start date: _____

End date (if applicable)_____

Are you interested in quitting? ☐ Yes ☐ No

Alcohol use:

- ☐ Yes
- ☐ No
- ☐ Occasionally

Type of alcohol:

- ☐ Beer
- ☐ Liquor
- ☐ Wine

If yes, how many drinks per week? _____

If yes, are you interested in quitting?

☐ Yes ☐ No

Drug Use:

- ☐ No present recreational drug use

☐ Past usage

Start date: _____

End date: _____

Type of drug: _____

☐ Present usage:

Start date: _____

Type of drug: _____

Frequency: _____

Are you interested in quitting?

☐ Yes ☐ No

Spiritual and Cultural practices: ☐ Yes ☐ No

If yes, please describe:_____

Are you currently accessing mental health and wellness/traditional healing services? ☐ Yes ☐ No

If yes, please describe: _____

Language spoken at home: ☐ Cree ☐ English ☐ Both ☐ Other:_____

Are you or your family impacted by:

☐ Residential School System	☐ Self	☐ Other: _____
☐ 60's scoop	☐ Self	☐ Other: _____
☐ Indian Day school	☐ Self	☐ Other: _____

What was your upbringing?

(Check all that apply)

- ☐ Birth family
- ☐ Single parent family
- ☐ Extended family
- ☐ Adopted
- ☐ Group Home
- ☐ Foster care
- ☐ Other: _____

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H. REQUEST FOR WHOLISTIC INTEGRATED SUPPORT SERVICES

Are you interested in learning about other services? (Check all that apply)

- ☐ Assistance with Substance Use Disorder (including Tobacco Cessation)
- ☐ Talk Therapy / Counselling
- ☐ Traditional Healing / Ceremonies
- ☐ Land Based Healing
- ☐ Myomassology
- ☐ Chiropractor
- ☐ Patient Advocacy / Navigation
- ☐ Foot Care
- ☐ Diabetic Retinal Screening
- ☐ NIHB Navigator
- ☐ Other: _____

ADDITIONAL INFORMATION: Please use this space to add any additional information that you would like to share.

Patient Signature:	**Date:**
SDM Signature:	*Date:*

INTERNAL USE ONLY
Date Intake Received:
Intake Received by:
Intake Appointment Date:
Intake Completion Date:
Intake Completed By:

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