MUSHKEGOWUK HEALTH PRIMARY CARE

NEW CHILD/YOUTH INTAKE FORM

A. CHILD/YOUTH INFORMATION: *for Children Ages 12 and under.*	
Given Name(s):	Surname:
Date of Birth: ______________________________ MM/DD/YYYY	Age:
Does the child/youth Identify as: ☐ Male ☐ Female ☐ Other	Phone Number: Can we leave a message here? ☐ Yes ☐ No
Address:	PO Box #:
City:	Province: / Postal Code:
First Nation (if applicable):	☐ Indigenous (Status) ☐ Indigenous (Non-Status)
Status #:	
Ontario Health Card #:	Health Card Expiry Date:

B. FAMILY INFORMATION	
1. Given Name:	**Last Name**
Relationship to Child:	Address: ☐ Same as applicant
Primary Contact Number:	Alternative Phone Number:
Email:	Contact Preference: ☐ Primary ☐ Alternative ☐ Email
2. Given Name:	**Last Name**
Relationship to Child:	Address: ☐ Same as applicant
Primary Contact Number:	Alternative Phone Number:
Email:	Contact Preference: ☐ Primary ☐ Alternative ☐ Email
Individual resides with: ☐ Both parents ☐ Mother ☐ Father ☐ Other: ______________________________	Number of Siblings: __________
Custody Status: ☐ Joint ☐ Mother ☐ Father ☐ Other	
Is the child/youth involved in any child and family services? ☐Yes ☐ No Name of service: ______________________________ Name of worker: ______________________________	

Please provide names and ages of siblings who reside in or outside the home.

Name	Age

Mushkegowuk Health, 11 Elm St. N. Timmins, ON, P4N 6A3, Ph 705-269-6662, TF 1-855-687-4492, Fax: 1-888-777-5708

C. PHYSICIAN/NURSE PRACTITIONER/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. REFERRAL/INFORMATION SOURCE: *Please indicate who encouraged you to come to the Clinic.*			
☐ Parent/Guardian	☐ Physician	☐ Agency	☐ Other: ______
Name:		Address:	
Telephone:		Fax:	

E. MEDICAL/BIRTH HISTORY: *Please complete to the best of your knowledge and recollection.*	
Birth History: ☐ Vaginal ☐ C-Section ☐ Full-Term ☐ Premature	Did Mother have any complications during pregnancy: ☐ Yes ☐ No If yes, please describe: ______ ______ ______
Birth Weight:	Any complications with baby at time of delivery: ☐ Yes ☐ No If yes, please describe: ______ ______
Current Weight:	
Current Height:	

F. MEDICAL HISTORY: *Please check boxes or list any medical conditions diagnosed since birth.*					
Developmental Delay	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	ADHD	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Other		
Diabetes	☐ Yes	☐ No	Other		
Heart Condition	☐ Yes	☐ No	Other		

G. SURGICAL HISTORY: *Please list any surgeries since birth and the location of facility and date.*	
Type of Surgery	Location and Approximate Date

H. MEDICATIONS: *Please list any medications taken on a regular basis including natural supplements.*	

I. PHARMACY: *Please provide name and contact information for your current and preferred pharmacy.*			
Pharmacy Name	Address	Phone	Fax
Pharmacy Preference:		☐ same as above	

J. ALLERGIES: *Please list any known or suspected allergies and describe type of reaction.*

Allergy to:	Reaction:

K. VACCINE INFORMATION: *Please provide/attach copy of vaccination record and/or list below.*

Are all vaccines up to date?	☐ Yes	☐ No	☐ Unknown
Any history of positive COVID?	☐ Yes	☐ No	☐ Unknown

Vaccine	**Date**
Please bring your immunization card/records	

L. SCHOOL or DAYCARE INFORMATION: *Please complete if child is in Daycare, School, or Other.*

Name of Child/Youth's Daycare/School/Other:	Grade:

Concerns regarding learning or development: ☐ Yes ☐ No

If yes, please describe: ____

____

____

____

Type of Placement: ☐ Regular/Full-time ☐ Not Enrolled	Individual Education Plan (specify): ____________________ Educational Assistant
Other	
Other	

M. FAMILY MEDICAL HISTORY: *Is there a history of either parents, or siblings having any of the following.*

CONDITION			**NAME/AGE of FAMILY MEMBER**	**DESCRIPTION**
Cancer	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
Asthma	☐ Yes	☐ No		
Depression	☐ Yes	☐ No		
Heart Attack	☐ Yes	☐ No		
Stroke	☐ Yes	☐ No		
Other				
Other				
Other				

Mushkegowuk Health, 11 Elm St. N. Timmins, ON, P4N 6A3, Ph 705-269-6662, TF 1-855-687-4492, Fax: 1-888-777-5708

N. ADDITIONAL COMMENTS:

Please use this section to add any additional information you would like to share.

____

O. PLEASE PRINT NAME, SIGN AND DATE IN BOXES BELOW.

Completed by (PRINT NAME):	Date completed:
Signature:	

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

Mushkegowuk Health, 11 Elm St. N. Timmins, ON, P4N 6A3, Ph 705-269-6662, TF 1-855-687-4492, Fax: 1-888-777-5708