Health Zone
Nurse Practitioner-Led Clinic

Adult Intake Form

This information is being collected under the Personal Information & Electronic Documents Act, January 2004. This will be used to provide the most appropriate professional care for your health needs and for research and statistical purposes. For more information, please ask our staff.

Demographics

First Name: _____ Last name: _____
Gender: _____ Date of birth: _____
Health card #: _____
Address & Postal code: _____
Home phone: _____ Cell phone: _____
Email address:_____
Emergency Contact Name & Info:_____
Mode of transportation (Bus, Car, Taxi, Walk, Paratransit)_____
Preferred Pharmacy: _____
Drug Coverage: Yes / No If yes, drug coverage provider: _____

Physician Information

Do you currently have a Family Doctor? Yes/No
If yes please provide name and phone number_____
_____
If no, when was your last visit with a doctor/nurse practitioner and where?_____
_____
Do you, or have you ever seen any specialists (cardiologist, psychiatrist, etc.): Yes / No
If yes, please provide name and phone number _____
_____

Social History:

Marital Status: _____
How many people live in your house/apartment: _____ How many under the age of 18?_____
What language(s) do you speak: _____ Ethnicity: _____
Where were you born? _____
Date of arrival in Canada (if born outside Canada): _____
Do you have any Spiritual/Religious/Ethnic considerations regarding your health care?
_____

Income Source:

- ☐ Employed
- ☐ EI
- ☐ Retired/Pension
- ☐ OW
- ☐ ODSP
- ☐ CPP
- ☐ Short Term Disability
- ☐ Long Term Disability

Occupation: _____
Employer: _____
Highest level of education: _____

Combined annual household income:

- ☐ $0-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$24,999
- ☐ $25,000-$29,999
- ☐ $30,000-$34,999
- ☐ $35,000-$39,999
- ☐ $40,000-$59,999
- ☐ $60,000-greater

<u>Community Organizations</u>

Are you involved with any of the following services (check all that apply)?

Community Centres

- ☐ My Sisters Place
- ☐ Crouch
- ☐ Westminster
- ☐ Other

Agencies

- ☐ Life Spin
- ☐ CCAC
- ☐ WAYS/Watch
- ☐ Cross Cultural Learners Centre (CCLC)
- ☐ Neighbourhood Legal Services
- ☐ South London Resource Centre
- ☐ Community Living
- ☐ At Lohsa Native Family Services
- ☐ Youth Action Centre

Services/Case Management

- ☐ Canadian Mental Health Association (CMHA)
- ☐ Child & Parent Resource Institute (CPRI)
- ☐ Daya Counseling Centre
- ☐ Children's Aid Society (CAS)
- ☐ London Abused Women's Centre (LAWC)
- ☐ SOAHAC
- ☐ London Health Sciences Centre
- ☐ Merrymount Children's Centre
- ☐ Addiction Services
- ☐ Victim Services
- ☐ Anova
- ☐ Thames Valley Children's Center
- ☐ Changing Ways
- ☐ Thames Valley Family Services
- ☐ Vanier

Other _____

_____

Health History for New Patients

Your answers on this form will help our staff understand your current and past medical concerns and conditions. If you do not remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Allergies or Intolerances: Please include type of reaction as well:

_____
_____
_____

Immunizations: ******Please bring a copy of your immunization record to your next visit****** Tetanus within the last 10 years?: yes/no

Health Maintenance Screening: Check off any tests you have had, result, and year if known:

- ☐ Colonoscopy (scope): Year_____ Result _____
- ☐ Fecal Occult Blood Test (FOBT): Year _____ Result_____
  *** FOBT kit will be provided if 50-74 years, average risk, and not done in last 2 years ***
- ☐ Bone density testing: Year _____Result _____
- ☐ Do you have a dentist? Yes / No Last dental check up:_____
  *** List of dentists provided if client does not have a dentist ***
- ☐ Do you wear glasses? Yes / No
- ☐ Have you had a recent eye exam: _____ Date of last exam:_____

If male:

- ☐ Prostate exam: Year_____Result_____

If female:

- ☐ Pap test: Year_____ Result_____
- ☐ Mammogram: Year_____ Result _____
  *** Ontario Breast Screening slip provided if >50 years, average risk, and not completed in past 2 years; or if >30 years, high risk, and not done in past year ***
- ☐ Are you currently pregnant? Yes / No
- ☐ Total number of pregnancies: _____ Number of births: _____
- ☐ ***For office use*** G: ___ T:____ P:____ A:_____ L:____
- ☐ Delivery method (i.e., vaginal, c-section) _____
- ☐ What years did you give birth/deliver? _____
- ☐ Any complications during pregnancy/delivery (i.e., gestational diabetes, high blood pressure, placenta issues)? Yes / No
  If yes, Please list: _____
- ☐ Age at end of periods (menopause), if applicable: _____
- ☐ Any issues with your periods? If so, please explain _____

Medical Issues and History:
Do you currently, or have you ever, experienced any of the following conditions? Please check and explain:

- ☐ Respiratory issues (i.e., asthma, COPD, emphysema, etc.):_____
  _____
- ☐ Heart issues (i.e., high blood pressure, cholesterol, heart attack): _____
  _____
- ☐ Skin issues (i.e., eczema, psoriasis, etc.):_____
  _____
- ☐ Gastrointestinal issues (i.e., irritable bowel syndrome, liver/gallbladder issues, colitis, etc.):
  _____
- ☐ Joint/muscle/bone issues: _____
  _____
  Broken bones:_____
- ☐ Gynecological issues (i.e., endometriosis, ovarian cysts, etc.):_____
  _____
- ☐ Renal/kidney issues (i.e., kidney stones, urinary tract infections):
  _____
- ☐ Endocrine issues (i.e., diabetes, thyroid dysfunction, etc.):_____
  _____
- ☐ Mental health issues (i.e., depression, anxiety, addictions, etc.):_____
  _____
- ☐ Neurological issues (i.e., stroke, migraines, seizures, etc.):_____
  _____
- ☐ Infectious diseases (i.e., HIV, Hepatitis, MRSA, etc.):_____
  _____
- ☐ Abnormal lab tests (i.e., low iron, low vitamin B12, etc.):_____
  _____
- ☐ Other: _____
  _____

Medications: Please list any medications you are currently taking, or provide a printed record (include all over the counter medications, vitamins, herbs, etc.):

_____
_____
_____

Surgical History: Please list any surgeries you have had, and approximate year of surgeries. Please include tonsillectomies, caesarian sections (C-sections), wisdom teeth extractions, etc.:

_____
_____
_____

Hospitalizations: Please list any previous hospital-stays overnight, and approximate years:

_____

_____

_____

Sexual History:

Are you currently sexually active? _____ Birth control method: _____

Do you have any sexual concerns? (i.e., sexuality, sexually transmitted infections (STI's), questions, educational needs):

_____

_____

_____

Any issues with your hearing? Yes / No

If yes please explain: _____

Tobacco Use: Smoking cigarettes: Yes No Never If yes: What age did you start smoking? _____ How many cigarettes per day? _____ Are you interested in quitting? _____	**Exercise:** Do you exercise regularly? Yes No What kind of exercise? _____ How long (minutes)?: _____ How often?: _____
Alcohol Use: Do you drink alcohol? Yes _____ No _____ If yes: # of drinks per week: _____ What age did you start drinking? _____	**Diet:** How would you rate your diet? Good Fair Poor Any dietary restrictions?_____ Would you like advice/help with your diet? Yes/No
Drug Use: Do you use marijuana or other recreational drugs? _____ Have you ever used needles to inject drugs? _____	**Sleep:** On average, how many hours do you sleep a night? _____ Trouble staying asleep? _____ Trouble falling asleep? _____

**** Social work intake checklist will be provided to client if social work services are needed****

Family History:

Do any of your family members have any of the following chronic medical issues? If yes, please specify which family member (i.e., mom, dad, sister, brother, grandparent, etc.)

- ☐ Heart Disease (Congestive Heart Failure, Heart Attack, Angina):_____
- ☐ High blood pressure_____
- ☐ Diabetes_____
- ☐ Stroke_____
- ☐ Asthma _____
- ☐ Seizures/epilepsy/convulsions_____
- ☐ Cancer (type) _____
- ☐ Mental health issues (depression, addictions, etc.)_____
- ☐ Autoimmune Disorders (thyroid, MS)_____
- ☐ Migraines_____
- ☐ Blood Disorders (Thalassemia, Sickle Cell, Anemia)_____

Other:_____
_____
_____

Have any of your family members passed away because of their illness? If so, please explain:

_____
_____
_____

Vitals (for in-clinic use only): **BP** **P** **Height** **Weight**

Protecting Your Privacy

Health Zone Nurse Practitioner Led Clinic (HZNPLC) is committed to protecting your personal information.

We have policies to protect the confidentiality of the personal information we hold about you
You can ask staff about our policies and practices related to the management of personal information
Every client or their legally authorized representative will sign an agreement about how we can use their personal information

We only collect and use information that is necessary to: provide care or services to you; evaluate, manage and plan our services; and meet our legal and funder requirements unless we are otherwise required by law.

We work in a team model where your information is shared about health providers involved in your care to be able to help you most effectively.

You can access your records by requesting to do so in writing.

Your information will not be released to any person or organization that is not a health care provider without your written or verbal consent, except under the following circumstances:

Where an individual appears to be a danger to themselves or others
Where child abuse is suspected
Where HZNPLC is required by law, statute, or regulation
Or as authorized

You have the right to withdraw your consent or to limit the information that you provide us. However, this may result in a change in the care that we can provide.

I, _____ have read and understand the above information on privacy.

_____ _____/_____/_____
Signature month day year

_____ _____/_____/_____
Witness month day year

If you have questions about HZNPLC's Privacy Policy, please ask any staff member.

EXPECTATIONS

Health Zone Nurse Practitioner Led Clinic (HZNPLC) management, staff, and students, agree to be courteous, professional, and respectful to clients at all times. HZNPLC will provide high quality, confidential services in an environment free of discrimination. In turn, clients of HZNPLC are expected to treat everyone in a courteous and respectful manner, without discrimination.

Nurse Practitioners (NPs) are able to provide most primary health care services, however:
NPs are ***not*** able to prescribe narcotics or controlled substances[1]

Off-site consulting physicians participate with our team and we can refer you to other health care providers, if needed.

AS A CLIENT/CLIENT GUARDIAN OF HZNPLC, I AGREE:

To be committed to maintaining and/or improving health
To treat others courteously, with respect and fairness, and without discrimination
To be accountable for my actions and to accept the consequences of my behaviour
To be on time for appointments and to call and cancel if I am not able to attend

AS A CLIENT/CLIENT GUARDIAN, I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS:

To express my opinion and be heard in a manner that is open, honest, and accepting
To be treated courteously, respectfully, fairly in a manner that fully recognizes my dignity, privacy, and individuality
To have my personal information kept confidential in accordance with the law
To be treated in a manner that is sensitive to my individual needs and preferences and which respects my individual differences including various ethnic, psychological, familial, spiritual, language or cultural factors
To raise concerns with or recommend changes in policies and services to HZNPLC
To be fully informed about the services provided to me, all aspects of my care, and who will be providing the services
To be informed of services and treatment options, to give consent or refuse consent for services and/or treatment and be informed of the consequences of this decision
To feel safe and free from all forms of abuse

I have read, understand and agree to the above Expectations of HZNPLC, the role of the Nurse Practitioner, and my Rights and my Responsibilities:

_____	_____	_____/_____/_____
Print name	Signature	month day year
_____	_____	_____/_____/_____
Witness	Signature	month day year

[1] College of Nurses of Ontario (2011). *Practice Standard—Nurse Practitioner.* Retrieved from http://www.cno.org/Global/docs/prac/41038_StrdRnec.pdf