Health Zone
Nurse Practitioner-Led Clinic

Pediatric Intake Form (age 0-17)

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 #: _____
Parent or Guardian:_____
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:

Spoken language(s): _____ Religion: _____
Country of birth: _____ _____ Ethnicity: _____
Date of arrival in Canada (if born outside Canada): _____
Current grade in school/preschool: _____ School name: _____
Is your child in daycare/before or after school care? YES or NO
Who lives in the home?_____
_____

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

_____

_____

_____

Immunizations: ***Please bring a copy of your immunization record to your next visit***

Birth & Pregnancy:

Were you/your child born premature/early? Yes or No

Were there any significant medical problems during pregnancy? Yes or No

Were there any significant complications during labor or as a newborn? Yes or No

If yes to any of the above questions, please explain: _____

_____

Growth and Development: Have there been any concerns about you/your child's growth or development (speech/language, social skills, motor skills etc.)? Y / N

If yes please explain:

_____

_____

_____

If school age, any concerns with behavior in school or learning ability? _____

_____

Medical History:

- ☐ Had any serious medical illness?
- ☐ Had a history of asthma or wheezing?
- ☐ Ever used an inhaler or nebulizer?
- ☐ Had surgery?
- ☐ Had any broken bones?
- ☐ Had any behavioral problems?
- ☐ Been hospitalized overnight?
- ☐ Puberty (girls - Menstruation?)

If yes to any of the above please explain (provide dates):

_____

_____

Family History: Please list any conditions/diseases that run in your family (i.e., does your mom/dad/sister/brother/grandparents have diabetes, heart conditions, mental health issues, etc.)

_____

_____

_____

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

_____
_____
_____
_____

Health Screening:

Do you have a dentist? _____ Date of last check up:_____ Any concerns?_____
Have you had an eye exam? _____ Date of last eye exam: _____
Result/need glasses? Yes/no
Hearing concerns? _____
Hearing test at birth? (yes/no), if yes was normal?_____
Would you say your diet is: Good Fair Poor
Any dietary restrictions?:
_____

Sleeping concerns?:_____

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

Ht: _____ **Wt: _____**

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, _____(parent/guardian) 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 (parent/guardian) 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