Health Zone

Nurse Practitioner-Led Clinic

Paediatric Intake Form (ages 0-17)

First Name: _____ Last name: _____ Gender: _____

Date of birth: _____ Health card #: _____

Parent or Guardian's name: _____

Address: _____Postal Code:_____

Home phone: _____ Cell phone: _____

Email address: _____

Emergency Contact Name & Info: _____

Preferred Pharmacy: _____

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: Check off any vaccinations you have had, and year of dose, if known. Please provide copy of immunization record.

Tetanus (Td) _____ with Pertussis (Tdap) _____	Varicella (chicken pox) shot *or* illness _____
Pneumovax (pneumonia)	Influenza (flu shot)
Hepatitis A	Hepatitis B
MMR (measles, mumps, rubella) _____	Zostavax (shingles) _____
Meningitis _____	HPV (human papilloma virus _____

Birth & Pregnancy:

Were you/your child born premature? 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: _____

_____

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?

™ If yes to any of the above please explain: _____

™ _____

™ **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?

_____

Have you had a hearing test? _____Date of hearing test:_____ Any concerns?

_____

Would you say your diet is: Good Fair Poor
Describe typical diet: _____
Hobbies: _____

™ **Protecting Your Privacy**

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

1) We have policies to protect the confidentiality of the personal information we hold about you
2) You can ask staff about our policies and practices related to the management of personal information
3) Every client or their legally authorized representative will sign an agreement about how we can use their personal information
4) 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
5) 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
6) 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, understand and agree to the above information on privacy.

™ _____ _____/_____/_____
Signature (or Parent/Guardian signature if under 16) month day year

™

™ _____ _____/_____/_____
Witness month day year

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

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™ 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

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

- To have my personal information kept confidential in accordance with the law
- To be treated in a 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 (or Parent/Guardian signature if under 16) month day year

™

™

™

™ _____ _____/_____/_____

Witness month day year

™