*Health Zone*
*Nurse Practitioner-Led Clinic*

*Business Office:*
*6 Barberry Court*
*P.O. Box 25087*
*London, ON N6C 6A8*

*Clinic Locations:*
*Merrymount Children's Centre – 1069 Colborne St.*
*Southdale – 1057 Southdale Rd. E.*
*Community Program Centre – 6 Barberry Crt.*

# NEW PATIENT APPLICATION FORM

☐ ***By initialing here I certify that the information below is correct to the best of my knowledge.***

☐ ***By initialing here I acknowledge that completing this registration form does not guarantee that I will become a patient at the Health Zone Nurse Practitioner-Led Clinic.***

☐ ***By initialing here I acknowledge that I understand I will not become a registered patient until AFTER attending an intake appointment with a Nurse Practitioner wherein my health information will be reviewed and a final decision will be made whether the Health Zone Nurse Practitioner-Led Clinic will accept me as a patient based on the Nurse Practitioner scope of practice.***

**Date Submitted:**

**Last Name:** _____ **Phone #:** _____
**First Name:** _____ **Address:** _____
**Date of Birth (dd/mm/year):** _____ _____
**Gender :** _____

**What is your source of income (employment, pension, social assistance)?**

**Do you currently have a primary health care provider (Nurse Practitioner/Physician)?**

NO

No Provide your <u>previous</u> Physician or Nurse Practitioner's name and address:

Yes Provide the Physician or Nurse Practitioner's name and address:

**Is someone in your family already a patient at the Health Zone NPLC?**

NO Provide their full name(s):

Are you currently on medication to manage a physical health concern?
**If you need more room, please list on the back**

| Medication | Dose | Reason for Taking | Current Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Current pharmacy name and address:** _____

***Applications can also be mailed to :***

1064 Colborne St.
London, ON N6A
Fax: 226-781-9805

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**Physician Information**
Do you, or have you ever seen any specialists (cardiologist, psychiatrist, etc.): NO
If yes, please provide name and phone numbers

**Health and Social History:**
What language(s) do you speak:

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

**Immunizations:**
Are all your immunizations up to date? NO

**Tobacco Use:**
Smoking cigarettes: NEVER
If yes:
What age did you start smoking? How many cigarettes per day?
Are you interested in quitting? MAYBE Do you use any other tobacco products? NO
Vaping: NEVER Does your vape contain nicotine? NO

**Alcohol Use:**
Do you drink alcohol? NO
If yes:
Number of drinks per week: What age did you start drinking?
In a typical month, how often do you have 5 or more drinks in a 24 hour period?

**Drug Use:**
Do you use cannabis, recreational or prescription drugs? NEVER
If yes, how often?
RARELY
Have you ever used needles to inject drugs? NO

**Diet:**
How would you rate your diet? POOR
Any dietary restrictions?
Are you having any issues with appetite or eating habits? NO
If yes:
☐ Eating less ☐ Eating more ☐ Heartburn
☐ Bingeing ☐ Restricting
Have you experienced significant weight change in the last 2 months? NO

**Sleep:**
On average, how many hours do you sleep a night?
Are you having any issues with: Poor quality sleep

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Other Other _____

**Legal Information**

Have you ever been convicted of a criminal offense? NO
If yes please explain _____

Are you currently involved in the legal system? NO

Have you ever experienced any of the following issues, please circle all that apply:

| **Difficulty** | **Yes** | **No** | **Difficulty** | **Yes** | **No** |
|---|---|---|---|---|---|
| Depressed mood/anxiety | Yes | No | Mood swings | Yes | No |
| Panic attacks | Yes | No | Phobias | Yes | No |
| Hallucinations | Yes | No | Frequent Body Aches | Yes | No |
| Body Image Problems | Yes | No | Repetitive thoughts | Yes | No |
| Repetitive behaviours | Yes | No | Homicidal thought | Yes | No |
| Suicidal thoughts/attempts | Yes | No | If yes, when? | | |

Have you experienced any of the following issues, please check all that apply:

| | | | | | |
|---|---|---|---|---|---|
| **Respiratory** | COPD | ☐ | **Skin** | Eczema | ☐ |
| | Asthma | ☐ | | Psoriasis | ☐ |
| | Other: | ☐ | | Other: | ☐ |
| **Heart** | High blood pressure | ☐ | **Gastrointestinal** | Irritable Bowel Syndrome | ☐ |
| | High cholesterol | ✔ | | Liver/Gallbladder concerns | ☐ |
| | Heart attack | ☐ | | Colitis | ☐ |
| | Other: | ✔ | | Other: | ☐ |
| **Gynecology** | Endometriosis | ☐ | **Joints/Muscles** | Broken bones | ☐ |
| | Ovarian cysts | ☐ | | Arthritis | ☐ |
| | Other: | ✔ | | Other: | ☐ |
| **Endocrine** | Diabetes | ☐ | **Kidney** | Kidney Stones | ☐ |
| | Thyroid dysfunction | ☐ | | Urinary Tract Infection | ☐ |
| | Other: | ☐ | | Other: | ☐ |
| **Mental Health** | Anxiety | ☐ | **Neurology** | Stroke | ☐ |
| | Depression | ☐ | | Migraine | ☐ |
| | Post Traumatic Stress Disorder (PTSD) | ☐ | | Seizure | ☐ |
| | Other: | ☐ | | Other: | ☐ |

Please list any persistent physical symptoms or health concerns:

Is there any family members that will be filling out an application also? Please list names below:

_____ _____
_____ _____
_____ _____

**Please note that completion of this application does not guarantee an appointment. Your application will be reviewed and you will only be contacted if we are able to accept the application based on the information given.