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.

First Name: _____ Last name: _____ Gender: _____
Date of birth: _____ Health card #: _____
Address: _____Postal Code:_____
Home phone: _____ Cell phone: _____
Email address: _____
Emergency Contact Name & Info: _____
Do you have transportation to the clinic? _____ Do you require transportation? _____
Preferred pharmacy: _____

Do you currently have a family doctor? If yes, what is your doctor's name, and what city are they in?
_____
If you do not have a family doctor, who was your last family doctor and when did you last see them?
_____
Do you have any specialist health care providers? If so, please list names and cities they work in:
_____

We are making every effort to accept all patients as quickly as possible. We recognize that there are some urgent and/or high risk situations that may take priority. To assist us with meeting your health care needs, please complete the area below:
Please check any of the following that apply to you at this time:

- ☐ Pregnancy
- ☐ Heart Disease (heart attack, angina)
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Newborn or infant under 2 years old
- ☐ Asthma, lung disease _____
- ☐ Seizures/epilepsy/convulsions
- ☐ Cancer (type) _____
- ☐ Depression/mental health issues

Other serious medical/social problems not listed above (please explain):
_____
_____

Social History:

Marital Status: _____
Number of people in your household: _____
Who, if anyone, do you live with? _____
Number of children: _____ Ages, if under 18 years old _____
Spoken language(s): _____ Religion: _____ Ethnicity: _____
Country of birth: _____ Date of arrival in Canada (if born outside Canada): _____

Other: This information will help us to provide programs and services in the community:

Source of income (please circle one): Employment Ontario Works (OW) ODSP Employment Insurance (EI) Retired/Pension

Occupation/Prior 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

Are you connected with any services in the community?(i.e., community centres, CAS, Cross Cultural Learning Centre, etc.) If so, please list:

_____

_____

_____

Health History for New Patients

Your answers on this form will help your health care provider get an accurate history of your 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: Check off any vaccinations you have had. Add year of last dose, if known:

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 _____

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

- ☐ Colonoscopy: Year_____ Result _____
- ☐ Bone density testing: Year _____ Result _____
- ☐ Do you have a dentist? _____ Last dental check up:_____
- ☐ If male:
  - Prostate specific antigen (PSA) test: Year _____ Result_____
  - Prostate exam: Year_____ Result_____
- ☐ If female:
  - Pap test: Year_____ Result_____
  - Mammogram: Year_____ Result _____

Women's Health:

Total number of pregnancies: _____Number of births: _____ Delivery method (i.e., vaginal, c-section) _____

First day of last period (if you are still menstruating): _____

Age at beginning of periods (menstruation): _____ Age at end of periods (menopause): _____

Any issues with your periods? If so, please explain

_____

Medical History: Do you have now (current) or have you had (past) any of the following conditions?

Condition	Current	Past	Comments
Alcohol/Drug abuse			Please specify:
Anemia			
Anxiety			
Asthma			
Arthritis			
Bladder/kidney problems			Please specify:
Blood clot			
Breast lumps (benign)			
Cancer			
Cataracts/glaucoma/vision problems			
Coronary Artery Disease			
Depression			
Diabetes			Type 1 or Type 2?
Emphysema/COPD			Please specify:
Fractures (broken bones)			Which bones?
Gallbladder issues			
Gastroesophageal reflux (heart burn/GERD)			
Gout			
Gynecological conditions			
Heart attack or stroke			
Hepatitis/liver disease			Which type?
High blood pressure			
High cholesterol			
Infectious/communicable disease			
Irritable Bowel Syndrome (IBS)			
Kidney stones			
Migraine headaches			
Osteoporosis			
Prostate issues			
Seizures/epilepsy			
Skin conditions			
Sleep apnea			
Stomach ulcer			
Thyroid issues			
Other			

Family History: (if known): Please indicate which relative has had the following diseases:

Condition	**Mom**	**Dad**	**Sister**	**Brother**	**Mom's mom**	**Mom's dad**	**Dad's mom**	**Dad's dad**	**Other relative (please specify)**
Alcoholism/Drug Abuse									
Alzheimer's/Dementia									
Bleeding/clotting disorder									
Cancer (breast)									
Cancer (colon)									
Cancer (ovarian)									
Cancer (prostate)									
Cancer (other _____)									
Coronary artery disease (heart attack, angina)									
Diabetes (childhood onset)									
Diabetes (adult onset)									
Genetic disease (explain:_____)									
Hepatitis									
High blood pressure									
High cholesterol									
Thyroid disease									
Kidney disease									
Kidney stones									
Mental health issues									
Migraine headaches									
Osteoporosis									
Other family history: _____ _____ _____ _____ _____									

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

_____

_____

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.:

_____
_____
_____
_____

Sexual History:

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

_____
_____
_____

Other:

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 Would you like advice or help with your diet? _____
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? _____ Any difficulties sleeping? _____ Trouble staying asleep? _____ Trouble falling asleep? _____

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 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	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