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.***

****Have you signed up at Health Care Connect Ontario for a Provider also?** Please Choose One

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

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

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

No Provide your previous 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 Yes 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: _____

Please mail, fax or email this form to Health Zone Nurse Practitioner-Led Clinic
1064 Colborne St.
London, ON N6A
Fax: 226-781-9805
reception@healthzonenplc.ca

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Physician Information
Do you, or have you ever seen any specialists (cardiologist, psychiatrist, etc.): Yes 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? Yes No

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? Do you use any other tobacco products? Yes No
Vaping: Yes No Never Does your vape contain nicotine? Yes No

Alcohol Use:
Do you drink alcohol? Yes 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? Yes No Never
If yes, how often?
Daily Weekly Monthly Rarely
Have you ever used needles to inject drugs? Yes No

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

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

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Sleeping too little Sleeping too much Other _____

Legal Information

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

Are you currently involved in the legal system? Yes 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.