Sunset Country FHT Nurse Practitioner Clinic

Intake Assessment Form

Please complete this form **prior** to attending your intake appointment. If you are unable to complete this form for any reason, please let us know. Unfortunately, we cannot provide any type of care services before your appointment. If you have urgent concerns in the meantime, please access care in another location.

The SCFHT NP Clinic collects, uses, and discloses your personal information in compliance with the guidelines of the Personal Health Information Policy Act (PHIPA). The information collected on this form will be used for the purposes of determining your eligibility for the clinic, primary care program & service planning, and Ministry of Health reporting. Your personal information will not be used for any other reason without your consent. We are required to keep your personal information confidential.

Demographics

Last Name: ____________________

First Name: ____________________

Preferred Name (if different from first name): ____________________

Date of Birth (day/month/year): ____________________

Pronouns (eg she/her, he/him, they/them): ____________________

Gender: ____________________

Language(s) spoken: ____________________

OHIP #: __________ Expiry date: __________

Mailing Address: ____________________

Home Address (if different from above): ____________________

Home Ph: __________ Cell Ph: __________ Work Phone Ph: __________ (Ext ______)

Messages ok? ❑ Home ❑ Cell ❑ Work

Email: ____________________

❑ I consent to have the SCFHT NP Clinic contact me via email for the purposes of appointment reminders, health & wellness education, and general clinic notifications.

Signature: ____________________

Emergency Contact

Last Name: ____________________

First Name: ____________________

Relationship: ____________________

Home Ph: __________ Cell Ph: __________ Work Phone Ph: __________ (Ext ______)

I would rate my health as: ❑ Excellent ❑ Good ❑ Okay ❑ Poor

What is most important to you right now? ____________________

Please tell us what your health & wellness concerns/goals are: ____________________

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How were you connected with the NP Clinic?
❑ Healthcare Connect - no previous provider
❑ Healthcare Connect - de-rostered from physician to join NP clinic
❑ Relationship with NP prior to clinic opening

If you have chosen to be de-rostered from your family physician, what was the reason?
❑ NP practice more suitable for my needs or preferences
❑ Not satisfied with current primary care services
❑ Other (please share): ____________________

Where have you been accessing care recently?
❑ Regular primary care provider: ❑ In Kenora
❑ Surrounding Area
❑ Out-of-Province
❑ Walk-in Clinic: ❑ In Ontario
❑ Out-of-Province
❑ Local Emergency Department
❑ Good Doctors Clinic
❑ Northwestern Health Unit

Name of previous primary care provider (Nurse Practitioner/Family Physician) and other members of your healthcare team:
____
____

When was the last time you saw a Nurse Practitioner or Family Physician? ____________________

Have you been hospitalized within the past 2 years? ❑ Yes ❑ No
Have you seen (now or in the past) any type of specialist for your medical issues? ❑ Yes ❑ No
If yes, please provide details and contact information:
____
____

Health Screening History

Do you wear glasses? ❑ Yes ❑ No
Optometrist: ____________ Most recent exam: ____________
Dentist: ____________ Most recent exam: ____________
Fecal Occult Blood Test (FOBT) Year: ____________ Result: ____________
Colonoscopy (year): ____________ Result: ____________
Last prostate exam (year, if applicable): ____________
Last PAP test (year, if applicable): ____________ Last mammogram (year, if applicable): ____________
Bone Density Test (year): ____________

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Immunizations

Please bring a copy of your immunization records with you. You can access this information online at: https://nwhu.icon.ehealthontario.ca/.

Medications

***Please contact your pharmacy to request a printed copy of your CURRENT medication list and bring it to your appointment.**

Preferred Pharmacy: ____________________

Do you need help or have any issues taking your medication? ❑ Yes ❑ No

List any supplements, over-the-counter or traditional medicines you are taking and the reason why:

____
____
____
____

Allergies, Sensitivities or Intolerances (please include type of reaction to each):

____
____
____
____

Health Information

How would you rate your stress level? ❑ None ❑ Low ❑ Medium ❑ High ❑ Severe

How many hours of sleep do you get per night on average? ____________________

What types of activities do you do to stay active? ____________________

How many hours per day are you sitting (ie. in front of TV/computer, at work)? ____________________

Do you have any dietary restrictions or preferences (eg. vegan, gluten-free, etc.)? ____________________

Are you a smoker?
- ❑ No (never smoked)
- ❑ Not currently, but in the past (quit date: ___________)
- ❑ Yes (current, want to quit)
- ❑ Yes (current, don't want to quit)

Do you have regular exposure to second- or third-hand smoke? ❑ Yes ❑ No ❑ Don't know

How many caffeinated beverages do you drink per day (coffee/tea/soda/energy drinks)? _____

Do you drink alcohol? ❑ Yes (# drinks/week _____) ❑ No

Do you use any type of recreational or "street" drugs?

❑ No ❑ Yes (details, please): ____________________

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Pregnancy History (if applicable)

Are you currently Pregnant? ❑ Yes ❑ No
How many pregnancies have you had (if applicable)? ________________________________
If you gave birth to children, how were they delivered? ❑ Vaginal ❑ C-section
Any complications or health issues during pregnancy or delivery? ❑ No ❑ Yes (please describe)
____

Health Problems

Do you currently, or have you ever, had any issues with the following (please provide details):
❑ Walking/Mobility (eg. pain, balance issue, use a cane/walker/wheelchair, have prosthetic limb)
❑ Vision or Hearing
❑ Difficulty Sleeping/Insomnia
❑ Mental Health (eg. anxiety, depression, eating disorders, schizophrenia)

____
____

❑ Heart (eg. high blood pressure, heart attack, high cholesterol)

____
____

❑ Breathing (eg. asthma, COPD, persistent cough)

____
____

❑ Stomach or Bowels (eg. heartburn/acid reflux, indigestion, diverticulosis)

____
____

❑ Endocrine (eg. diabetes, thyroid disease)

____
____

❑ Skin (eg. eczema, psoriasis, acne, concerning moles)

____
____

❑ Liver, gallbladder or kidneys/urinary tract (eg. hepatitis, kidney stones, bladder infections)

____
____

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❑ Breasts/uterus/ovaries/vagina (eg. period symptoms, infertility/pregnancy loss, infections, pelvic pain)

____

____

❑ Penis/testicles/prostate (eg. infection, cysts, cancer, BPH)

____

____

❑ Joints, muscles or bones (eg. arthritis, osteoporosis, ongoing pain)

____

____

❑ Nervous System (eg. migraine headaches, seizures, stroke)

____

____

❑ Past/Current Infections

____

____

❑ Abnormal Test Results

____

____

Past Surgeries

Surgery	Year

Family History

Please list any medical conditions for the following family members:

Your Mother: ______________________________

Your Father: ______________________________

Mother's Parents: ______________________________

Father's Parents: ______________________________

Your Siblings (if any): ______________________________

Your Children (if any): ______________________________

Your Grandchildren (if any): ______________________________

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Sunset Country Family Health Team

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The following questions are asked to help us understand your risk for health issues based on the social determinants of health

Do you identify as any of the following (please check all that apply to you):
❑ First Nation, Métis or Inuit
❑ Racial or ethnic minority
❑ Recent Immigrant
❑ Disabled
❑ Elderly
❑ LGBTQ

Living Conditions

Where do you live (ie. type of building)? ______

Who lives with you? (include pets): ______

Do you feel safe where you live ______

Rate the condition of the building you live in: ❑ Excellent ❑ Good ❑ Okay ❑ Poor
Does your home have heat and/or air-conditioning? ❑ Both ❑ Heat Only ❑ None
Type of heat: ❑ wood ❑ forced air ❑ baseboard heaters ❑ space heaters ❑ other
Have you ever been homeless? ❑ Yes ❑ No

Relationship Status/Social Supports

❑ No relationship currently
❑ Exclusive/Committed Dating
❑ Married (# yrs _____)
❑ Divorced
❑ Casual: # of partners over past year _____
❑ Common Law
❑ Separated
❑ Widowed

Do you have friends or family that live in your community? ❑ Yes ❑ No

Early Childhood Conditions

Were you breastfed as a baby? ❑ Yes (how long? _________) ❑ No ❑ I don't know
Did you experience any of the following during childhood?
❑ Physical abuse
❑ Sexual abuse
❑ Emotional abuse
❑ Physical neglect
❑ Emotional neglect
❑ Intimate partner violence
❑ Mother treated violently
❑ Substance misuse within household
❑ Household mental illness
❑ Parental separation or divorce
❑ Incarcerated household member

Highest Level of Education

❑ No formal education ❑ Grade School ❑ High School
❑ College/University ❑ Trade/Technical School ❑ Graduate

Employment & Working Conditions

Income Source:
❑ Employed ❑ EI ❑ Retired/Pension ❑ Ontario Works
❑ ODSP ❑ CPP ❑ Disability

Combined Annual (per year) Household Income:
❑ Less than $16,200 ❑ $16,200 to $29,300 ❑ $29,300 to $40,300
❑ $40,300 to $54,200 ❑ $ 54,200 to $88,800 ❑ $ 88,800 or higher

How many people are being supported on this income? _______________
Are you ever "short" on money or have difficulty paying bills? ❑ Yes ❑ No
Occupation/Job: ____________________________ # hours worked per week: _________
Shift work? ❑ Yes ❑ No
Does your employer give you time off to attend medical appointments? ❑ Yes ❑ No
Rate your work-related stress: ❑ Low ❑ Medium ❑ High ❑ Very High
Do you have health/drug benefits through your employer? ❑ Yes ❑ No
Do you have other health or drug coverage? ❑ Yes (details, please: ______________) ❑ No

Access to Healthy Food/Food Insecurity

Have you ever used a food bank or shelter to access meals? ☐ Yes ☐ No
Do you ever worry about you or your family not having enough to eat? ☐ Yes ☐ No
Do you have difficulty affording healthy food? ☐ Yes ☐ No
Where do you shop for groceries/food items? ____________________________________
Do you have difficulty finding the types of foods you like to eat in local stores? ❑ Yes ❑ No

Transportation

How will you be coming to appointments at the clinic?
❑ Personal vehicle ❑ Friend/relative will drive me ❑ Bus ❑ Taxi
❑ Medical Van ❑ Handi-Transit ❑ Other: ______________________________

Community Health Services/Organizations

Do you receive services from any of the following (check all that apply):
❑ Acupuncture
❑ Alzheimer's Society
❑ Canadian Mental Health Association (CMHA)
❑ CCAC
❑ Chiropractor
❑ Community Mental Health Support
❑ Firefly

- ❑ Healing Touch/Energy Therapy
- ❑ Kenora Association for Community Living
- ❑ Kenora Chiefs Advisory
- ❑ Kenora Midwives
- ❑ Kenora Recreation Centre
- ❑ Kenora Sexual Assault Centre
- ❑ Massage
- ❑ Naturopathic Doctor (ND)
- ❑ Northwestern Health Unit
- ❑ Physiotherapy
- ❑ Saakaate House (Women's Shelter)
- ❑ SPACE Kenora
- ❑ Traditional Medicine
- ❑ Victims Crisis Assistance & Referral Service (VCARS)
- ❑ Waasegiizhig Nanaandawe'iyewigamig Health Access Centre
- ❑ Women's Place
- ❑ Other(s): ______________________________