

MUSHKEGOWUK HEALTH OMA PRIMARY CARE NEW CHILD/YOUTH INTAKE FORM



Date: (Month Day Year)						
CHILD/YOUTH INFORMATION: for Children Ages 12 and Under.						
Given Name(s):	Surname					
Date of Birth:	Age:					
Does the child/youth Identify as:	Home P	hone:				
□ Male □ Female □ Non-Binary □ Other	leave a message here? Yes No					
Address:	•		PO Box #:			
City:	Province	2:	Postal Code:			
Does the child/youth have a Family Physician/Nurse Practitioner: Yes No						
If so, please provide Name, Office, and Phone Nu	mber:					
First Nation (if applicable):	Status #	(if applicable):				
Indigenous (status) Indigeno	us (non-sta	tus) Metis	Other			
Ontario Health Card #:						
FAMILY INFORMATION						
Parent/Guardian Name:		Parent/Guardian Name:				
Relationship:		Relationship:				
Address:		Address:				
Primary Contact Number:	Home	Primary Contact Nui	Home			
N	Mobile	,		Mobile		
V	Nork		Work			
Individual resides with: Both parents Other:	ther 🗆 F	ather				
Number of Siblings:						
Custody Status: Joint Mother	Fath	ner Other				
Is the child/youth involved in any child and family						
Name of service:						
Name of worker:						
FAMILY INFORMATION:						
Please provide names and ages of siblings who reside in or outside the home.						
Name		Age				



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REFERRAL/INFORMATION SOURCE: Please indicate who encouraged you to come to the Clinic.							
Parent/Guardian Physician				Agency Other:			
			ress:				
Telephone:			Fax:				
	MEDI	CAL/BIF	RTH	HISTORY:			
	Please complete to the I	best of y	our	knowledge and recolle	ction.		
	inal C-Sec -Term Prem	ction ature		Yes	complications during portions of the complications during portions of the complex		
Birth Weight:				Any complications wi	th baby at time of delive	ery:	
Current Weight:			Yes No If yes, please describe:				
Current Height:							
	M	EDICAL	HIS	TORY:			
Plea	se check boxes or list an				since birth.		
Developmental Delay	Yes	No		pilepsy	Yes	No	
Asthma	Yes	No	Α	DHD	Yes	No	
Eczema	Yes	No	o Other				
Diabetes	Yes	No	Other				
Heart Condition	Yes	No	0	ther			
SURGICAL HISTORY:							
Please list any surgeries since birth and the location of facility and date.							
Type of Surgery				Location and Approximate Date			
AAFDIGATIONG							
MEDICATIONS: Please list any medications taken on a regular basis including natural supplements.							
					• •		
ALLERGIES: Please list any known or suspected allergies and describe type of reaction.							
Allergy to:			- 3		ction:		
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VACCINE INFORMATION:								
Please provide/attach copy of vaccination record and/or list below.								
Are all vaccines up to			Yes	No	Unkno	wn		
Any history of positiv	e COVID?		Yes	No	Unkno	wn		
		Va	accine					Date
SCHOOL or DAYCARE INFORMATION:								
		Please			Daycare, School			
Name of Child/Youth	's Davcare			Cilia is iii i	sayeare, serioor	, or other.	-	Grade:
Concerns regarding le				Yes	No			
If yes, please describe	_							
Type of Placement:					Special Education (specify):			
Regular/Full-time			Not Enrolled					
								
							Educat	tional Assistant
Other								
Other								
FAMILY MEDICAL HISTORY: Is there a history of either parents, or siblings having any of the following:								
	Is the	re a histo						g:
CONDITION	.,		NAME/AGI	e of FAMILY	MEMBER	DESCR	IPTION	
	Yes	No						
	Yes	No						
Asthma	Yes	No						
•	Yes	No						
	Yes	No						
Other	Yes	No						
Other								
Other								
Otilei								



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ADDITIONAL COMMENTS:				
Please use this section to add any addition	onal information you would like to share.			
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	AND DATE IN BOXES BELOW.			
Completed by (PRINT NAME):	Date completed:			
Signature:				