MUSHKEGOWUK HEALTH
Okimawiwin Minopimatisiwinik Atoskawikamik

MUSHKEGOWUK HEALTH OMA PRIMARY CARE NEW PATIENT INTAKE FORM

MUSHKEGOWUK COUNCIL

CLIENT INFORMATION

Full name as it appears on your Health Card.

First Name: _____ Middle Name(s): _____

Last Name: _____

Preferred Name:

Date of Birth:	Age:

Do you Identify as: □ Male □ Female □ Non-Binary □ Other	Do you Identify as LGTBQ2+ ☐ Yes ☐ No ☐ Other _____
Home Phone: _____ Can we leave a message here? □ Yes □ No	Cell Phone: _____ Can we leave a message here? ☐ Yes □ No

Email:

Address:	PO Box #:

City:	Province:	Postal Code:

Do you have a status card? □ Yes □ No □ I don't know □ Not Applicable
**Consent required for us to assist you if needed*

First Nation:	Status #:

Ontario Health Card #:

EMERGENCY CONTACT / NEXT OF KIN / POWER OF ATTORNEY INFORMATION

To be contacted in the event of an emergency (ex: hospitalization)

Name of contact: _____ Relationship: _____ Phone #: _____ Email: _____	Alternate contact: _____ Relationship: _____ Phone #: _____ Email: _____

IF COMPLETING THIS FORM FOR A MINOR OR ADULT DEPENDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Legal Guardian(s) Name: _____ Address: _____ Phone: _____
Legal Guardian(s) Name: _____ Address: _____ Phone: _____
Your relationship to the patient: _____

Individual resides with: ☐ Both parents ☐ Mother ☐ Father ☐ Caregiver ☐ Relative: _____
☐ Group home ☐ Alone ☐ Other: _____

Is the child involved in any child and family services? □ Yes □ No

Name of service: _____
Name of worker: _____

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PHYSICIAN/NURSE PRACTIONER/SPECIALIST INFORMATION:

Do you have a physician, nurse practitioner or specialist that you are seeing? ☐ Yes ☐ No

NAME: _____
OFFICE:_____
PHONE NUMBER:_____

NAME:_____
OFFICE:_____
PHONE NUMBER:_____

TESTS AND SCREENING **DATE:**

When was the last time you had any blood work: ☐ Unknown

Who has been providing your prescriptions: ☐ Not Applicable

CURRENT MEDICATION LIST (Including herbs, traditional medicine, and supplements)

Medication (include patches, creams, puffers, birth control & marijuana use)	**Dose**	**Frequency**	**Route (i.e. mouth, injection etc.)**
Herbs/Supplements			

**Please remember to bring in ALL your medications you take when you have been contacted for an Intake appointment.

PHARMACY: Please provide name and contact information for your current and preferred pharmacy.

Pharmacy Name	Address	Phone	Fax

Pharmacy preference:

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MEDICAL HISTORY (Please check any you have been diagnosed with in the past)

Anemia		HIV/AIDS	
Anxiety		Irregular heartbeat	
Arthritis		Irritable bowel syndrome	
Asthma		Kidney Failure	
Bleeding disorders		Kidney stones	
Blood clots		Multiple sclerosis	
Cancer		Pacemaker/defibrillator	
Cataracts		Pancreatitis	
Chronic Obstructive Pulmonary Disease		Parkinson's disease	
Congestive heart failure		Polyps	
Crohn's disease		Rheumatoid arthritis	
Depression		Schizophrenia	
Diabetes ☐ type I ☐ type II		Seizures	
Difficulty hearing		Sleep apnea	
Diverticulitis		Stroke or paralysis	
G.E.R.D.		Substance or alcohol use/addiction	
Glaucoma		Suicide thoughts or attempt	
H. Pylori		Thyroid disease	
Heart Attack		Tuberculosis	
Heart murmur		Ulcerative colitis	
Hepatitis or Liver disease		Ulcers of stomach or intestine	
Hernia		Urinary tract infections	
High blood pressure		Other: _____	
High cholesterol		Other: _____	
History of falls		Other neurological problems: _____	
		Other mental illness:_____	

May use this area to add description if desired. _____

_____

_____

PAST SURGICAL HISTORY: Please list any prior surgeries

TYPE OF SURGERY	DATE	HOSPITAL

Allergies: Please list any allergies you have and your reaction (minor, major or life-threatening)

_____

_____

_____

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FAMILY HISTORY: Is there a history of either **parents** or **siblings** having any of the following:		
Condition	**Name /Age of Family Member**	**Description of Illness**
Cancer □ Yes □ No		
Diabetes □ Yes □ No		
Stroke □ Yes □ No		
Heart Attack □ Yes □ No		
Depression □ Yes □ No		
Asthma □ Yes □ No		
Other		
Adopted/Unknown		

WOMENS HEALTH		
Date of last menstrual period:	□ Regular □ Irregular	
Last pap test:	□ Normal □ Abnormal	
Pregnancies:	# of Pregnancies: _____ # of Deliveries: _____ # of Miscarries:_____ # of Terminations: _____	
Mammogram:	□ Normal □ Abnormal	
Other:		

MENS HEALTH		
Last PSA:	Date:	Normal □ Abnormal □Unknown
History of prostate cancer □ Yes □ No	Date:	Describe:
Other:		Describe:

PREVENTATIVE CARE
Have you ever had a colonoscopy?
Have you ever completed a take home Colon Cancer Stool Screening Test?
Have you ever had a Bone Mineral Density Test?

VACCINATION HISTORY	
VACCINE	**DATE**:
Influenza	
Covid-19	
HPV	
Hepatitis	
Tetanus	
Shingles	
Are your vaccines up to date? □ Yes □ No □ Unknown	
Other	

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SOCIAL HISTORY

Personal: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
☐ Single parent ☐ Co-parenting # number of children_____

Education Level: ☐ Elementary ☐ High School ☐ College/University ☐ No formal education
Did you attend residential school? ☐ Yes ☐ No

Employment: ☐ Full time ☐ Part time ☐ Retired ☐ Other _____
☐ Currently unemployed Occupation: _____
If employed, do you receive health benefits? ☐ Yes ☐ No

Tobacco Use: ☐ Yes ☐ No If yes, how many packs per week? _____
If yes, are you interested in quitting? ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No If yes, how many drinks per week? _____
If yes, are you interested in quitting? ☐ Yes ☐ No

Marijuana Use: ☐ Yes ☐ No Form: _____
If yes, are you interested in quitting? ☐ Yes ☐ No
Drug Use: ☐ Yes ☐ No If yes, what type of drugs? _____
If yes, are you interested in quitting? ☐ Yes ☐ No

Spiritual and Cultural practices: ☐ Yes ☐ No
If yes, please describe:_____
Are you currently accessing mental health and wellness/traditional healing services? ☐ Yes ☐ No
If yes, please describe:
_____

Language spoken at home: ☐ Cree ☐ English ☐ Both Other:_____

Are you or your family impacted by:
☐ Residential School System ☐ Self ☐ Other: _____
☐ 60's scoop ☐ Self ☐ Other: _____
☐ Indian Day school ☐ Self ☐ Other: _____

What was your upbringing? (Check all that apply)

☐ Birth family ☐ Single parent family ☐ Extended family ☐ Adopted ☐ Group Home

☐ Foster care ☐ Other: _____

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REQUEST FOR WHOLISTIC INTEGRATED SUPPORT SERVICES

Are you interested in learning about any other services? (Check all that apply)

- ☐ Mental Health and Wellness
- ☐ Assistance with Substance Use Disorder
- ☐ Tobacco Cessation
- ☐ Psychotherapy and Indigenous Counselling
- ☐ Naloxone Training / Harm reduction
- ☐ Traditional Healer
- ☐ Land Based Healing
- ☐ Myomassology
- ☐ Chiropractor
- ☐ Patient Advocacy/Navigation
- ☐ Diabetes Education
- ☐ Foot Care
- ☐ NIHB Navigator
- ☐ Other: _____

ADDITIONAL INFORMATION: Please use this space to add any additional information that you would like to share.

Patient Signature: _____ **Date:**_____

Substitute decision maker: _____ *Date:*_____

INTERNAL USE ONLY
Date Intake Received:
Intake Received By:
Intake Completion Date:
Intake Completed By:

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