MISIWAY
Milopemahtesewin
Community Health Centre
www.misiway.ca

Please complete this package so that we may process your request to become a patient of Misiway Milopemahtesewin Community Health Centre's Primary Care clinic.

The completion of this package begins our New Patient Intake process. If our Health Care Providers are not able to accommodate new patients, you may be waitlisted until an opening is available.

During your intake appointment with our Clinic Registered Nurse, you will be presented with information regarding:

- the **minimal prescription of narcotics** through our chronic pain management program
- prescription renewal processes

Following the intake appointment, the Registered Nurse will review your information and work with our team to determine the best Provider for your health care needs. You will then be notified about your Primary Care Provider by telephone, and invited to book your first appointment.

Please note that our Primary Care Providers are unable to complete documents such as ODSP forms without first having an established relationship with you over multiple appointments.

Thank you

Meegwetch

Misiway Milopemahtesewin Community Health Centre
130 Wilson Ave., Timmins, Ontario P4N 4R5 Phone: 705-264-2200 Fax: 705-267-5688

New Client Intake Form

Demographics

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*_____

Date of Birth: (DD,MM,YYYY)_____

Address: _____ **City:**_____ **Postal Code:** _____

Telephone Number: _____ **Alternate Number:** _____

Health Card Number: _____ **Version Code:**_____ **Expiry:** _____

Status Card Number: _____ **Band Name:** _____

Spoken Language:_____ **Religion:** _____

Race/Ethnic Origin: (circle) First Nation Metis Other_____

Country of Origin: (circle) Canada Other _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐Divorced ☐Widowed

Living Arrangement: Alone **Family:** Spouse Children Parents Siblings

Extended Family **Friends** **Foster Family** **Boarding Home**

IN CASE OF EMERGENCY:

Contact Name(s):_____ Relationship:_____

Phone Number: _____

Name of pharmacy you use: _____

Do you currently have a healthcare provider? YES NO

If yes, please provide name of health care provider _____

Have you ever been a client of Misiway? YES NO

If yes, who was your primary health care provider? _____

Date of last physical exam: _____

Personal Health History

Childhood Illness: ☐ Measles ☐Mumps ☐Chickenpox ☐Rhuematic Fever ☐Polio ☐None

Immunizations and Dates: ☐Tetanus_____ ☐ Pneumonia_____ ☐ Hepatitis A _____

☐Chickenpox_____ ☐Influenza_____ ☐MMR *Mealsels, Mumps, Rubella*_____

☐Menningococcal_____ ☐None _____

Tests/Screenings and Dates: ☐Eye Exam_____ ☐ Colonoscopy_____ ☐LabTesting_____

☐Meningococcal_____ ☐Tuberculosis (TB) Skin test or chest X-ray _____

Surgeries:

Year:_____ Reason: _____ Hospital:_____

Year:_____ Reason: _____ Hospital:_____

Year:_____ Reason: _____ Hospital:_____

Year:_____ Reason: _____ Hospital:_____

Other Hospitalizations:

Year:_____ Reason: _____ Hospital:_____

Year:_____ Reason: _____ Hospital:_____

Year:_____ Reason: _____ Hospital:_____

Year:_____ Reason: _____ Hospital:_____

☐I have never been hospitalized

Have you ever had a blood transfusion? ☐Yes ☐No

Please list other physicians you have seen in the last 12 months, and for what reason.

_____
_____
_____
_____
_____
_____

Your Medical History

Please indicate if **YOU** have a history of the following:

☐Alcohol Abuse
☐ Anemia
☐Anesthetic Complication
☐ Anxiety Disorder
☐Arthritis
☐Asthma
☐Autoimmune Problems
☐ Birth Defects
☐ Bladder Problems
☐ Bleeding Disease
☐ Blood Clots
☐ Blood Transfusion(s)
☐ Bowel Disease
☐ Breast Cancer
☐ Cervical Cancer
☐Colon Cancer
☐ Depression
☐ Diabetes
☐ Migraines
☐ Osteoporosis
☐Pain/Chronic Pain
☐ Prostate Cancer
☐ Rectal Cancer
☐ Reflux/GERD
☐ Seizures/Convulsions
☐ Severe Allergy
☐ Sexually Transmitted Disease
☐ Skin Cancer
☐ Stroke/CVA of the Brain
☐ Suicide Attempt
☐Thyroid Problems
☐ Ulcer
☐ Visual Impairment
☐ Other Disease, Cancer, or Significant Medical Illness
☐ NONE of the Above

List other past medical problems:_____
_____
_____
_____
_____
_____
_____
_____

Medications, Nutritional Restrictions and Supplements

Medications – Please list all medications (prescription and over the counter) you are currently taking.

Medication	Physician Contact#	Length of Time	Dose	Frequency
For example: Ibuprofen	OTC	1 Week	400 mg	2 x day

☐ I take no medications, vitamins, herbals or any over the counter preparations.

☐ Additional medications listed on back of questionnaire.

☐ I give authorization for Misiway CHC to call my pharmacy to request an up to date list of my medications.

Allergies

Name: _____ Reaction you had: _____

☐ I have no known **drug** allergies.

Nutrition Restrictions:

☐Lactose intolerance ☐Salt Restricted ☐Other food intolerances/allergies: _____

☐Religious (Kosher, Halal, etc.) ☐Vegan Diet

☐Vegetarian Diet ☐Gluten-free Diet

Nutritional Supplements – Please use the chart below to list all vitamins, minerals, amino acids, or other supplemental products (meal replacement drinks, bars, etc.) you are currently taking.

Supplement	Brand	Form	Dose/Frequency	Length of Time
For example: Vitamin E	*Nature's Made*	*Soft Gel Cap*	*400IU 1 X day*	*6 months*

Family Medical History

Please indicate if **YOUR FAMILY** has a history of the following: *(**ONLY** include parents, grandparents, siblings and children)*

☐ I am adopted and do not know biological family history

☐ Family History Unknown

☐ Alcohol Abuse

☐ Anemia

☐ Anesthetic Complication

☐ Arthritis

☐ Asthma

☐ Bladder Problems

☐ Bleeding Disease

☐ Breast Cancer

☐ Colon Cancer

☐ Depression

☐ Diabetes

☐ Heart Disease

☐ High Blood Pressure

☐ High Cholesterol

☐ Kidney Disease

☐ Leukemia

☐ Lung/Respiratory Disease

☐ Migraines

☐ Osteoporosis

☐ Other Cancer

☐ Rectal Cancer

☐ Seizures/Convulsions

☐ Severe Allergy

☐ Stroke/CVA of the Brain

☐ Thyroid Problems

☐ Mother, Grandmother, or Sister developed heart disease before the age of 65

☐ Father, Grandfather, or Brother developed heart disease before the age of 55

☐ NONE of the Above

Social History

Exercise

Do you exercise? ..... ☐Y ☐N

If yes, how many minutes per week?_____

Diet

Are you dieting? ☐Y ☐N If yes, are you on a physician prescribed medical diet? ☐Y ☐N

Number of meals you eat in an average day?_____

Rank salt intake ☐ Hi ☐ Med ☐ Low

Rank fat intake ☐ Hi ☐ Med ☐ Low

Caffeine ☐ None ☐ Coffee ☐ Tea ☐ Cola Number of cups/cans per day?_____

Do you drink alcohol?..... ☐Y ☐N

Alcohol

If yes, what kind?_____ How many drinks per week?_____

Are you concerned about the amount you drink?..... ☐Y ☐N

Have you considered stopping?..... ☐Y ☐N

Have you ever experienced blackouts?..... ☐Y ☐N

Are you prone to "binge" drinking?..... ☐Y ☐N

Do you drive after drinking?..... ☐Y ☐N

Tobacco

Do you use tobacco?..... ☐Y ☐N

☐ Cigarettes – pks./day_____ or pks./week _____

☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____

Number of years_____ ☐ Previous tobacco user - year quit _____

Drugs

Do you currently use recreational or street drugs?..... ☐Y ☐N

If yes, which drugs are you using?_____

Have you ever given yourself street drugs with a needle? ..... ☐Y ☐N

☐I prefer to discuss with the physician

Sex

Are you sexually active?..... ☐Y ☐N

If yes, are you and your partner trying for a pregnancy? ..... ☐Y ☐N

If not trying for a pregnancy list contraceptive or barrier method used:_____

Any discomfort with intercourse?..... ☐Y ☐N

Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse.

Would you like to speak with your provider about your risk of this illness?..... ☐Y ☐N

Mental Health

Is stress a major problem for you? ..... ☐Y ☐N

Do you feel depressed? ..... ☐Y ☐N

Do you panic when stressed? ..... ☐Y ☐N

Do you have problems with eating or your appetite?..... ☐Y ☐N

Do you cry frequently?..... ☐Y ☐N

Have you ever attempted suicide? ..... ☐Y ☐N

Have you ever seriously thought about hurting yourself? ..... ☐Y ☐N

Do you have trouble sleeping? ..... ☐Y ☐N

Have you ever been to a counselor?..... ☐Y ☐N

Section 3 – Symptom Review

Circle the symptoms that you are experiencing.

General
Weight Change
Fever
Fatigue
Chills
Night Sweats
Appetite Change
Sleep Problems

Skin
Itching Rash
Mole Change
Hair Change
Colour Change
Non-healing sores

Eyes
Vision Change
Double Vision
Pain
Spots/Floaters
Itching
Watering
Redness

Ears
Ear Pain
Hearing Loss
Use of Hearing Aid
Ringing in Ears

Nose
Nose bleeds
Congestion
Runny Nose
Itching
Sinus Problems

Mouth, Throat
Teeth problems
Mouth Sores
Sore Throat
Difficulty Swallowing
Hoarseness

Neck
Lump
Swollen Glands
Pain

Breasts
Lump
Pain
Nipple Discharge

Heart/Vessels
Chest Pain
Swelling feet/legs
Palpitations
Murmur
Calf pain with walking
Varicose Veins
Easy Bruising/Bleeding

Stomach
Heartburn
Nausea/Vomiting
Diarrhea
Constipation
Bowel Changes
Bloody Stools
Abdominal Pain
Excessive gas/belching
Hemorrhoids

Urinary
Burning
Frequent Urination
Painful Urination
Blood in Urine
Reduced Urine Flow
Hesitancy
Dribbling
Wake up to urinate
Incontinence

Muscle/Skeletal
Joint Pain
Joint Swelling
Joint Redness
Neck Pain
Back Pain
Muscle Pain

Neurological
Paralysis
Seizures
Fainting
Muscle weakness
Balance Problems
Coordination Problems
Numbness
Tremors
Memory Changes
Headache

Emotional
Depression
Trouble Sleeping
Nervousness
Anxiety
Stress
Trouble Concentrating

Female Reproductive
Abnormal Vaginal Bleeding
Hot Flashes/Night Sweats
Problems with sex
Vaginal Discharge
Vaginal Dryness
Vaginal Itching
Painful Intercourse
Painful Periods
Irregular Periods
PMS
Genital sores

Male Reproductive
Discharge from penis
Sores on penis
Testicular Pain
Testicular Lump
Problems with Sex
Erection Problems
Prostate Problems

Section 4 – Other Information

Your healthcare provider needs to know:

Do you have any religious or cultural beliefs that may impact your healthcare?..... ☐Y ☐N

If yes, please describe: _____

_____

I learn new information best by: ☐Verbal instructions ☐Written instructions ☐Pictures

Level of education completed: ☐Less than High School ☐High School diploma or GED

☐1-4 years of Post-Secondary Education ☐ >4 years Post-secondary Education

I understand English well. ☐Y ☐N If no, what language do you prefer?_____

☐**I have read and understand the following attached documents:** No-show Policy, Prescription Refill Policy.

Patient's Signature:_____ Date: _____

Reviewed By:_____ Date: _____

PRESCRIPTION RENEWAL NOTICE

Please note that prescription requests will not be taken over the phone. You are required to call your local pharmacist and request that your prescription renewal be faxed to our office.

Kindly remember, we require up to
two weeks notice for all prescription renewals.

Thank you for your cooperation.

Meegwetch!