

Request for Services at NorWest CHCs

Last Name	First Name
Preferred Name	Date of Birth
Home Address / Postal Code	e-mail address (optional)
Home Phone Number / Cell Number	Name and Phone Number of Emergency Contact
HIN #	Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Transgender
Legal Guardian(s) Name and Address (If child under 16)	
Pharmacy Name and Address	
Name of Previous Physician and/or Specialists and Locations	
Physician(s): _____	
Specialist(s): _____	
Do you have a hearing impairment: <input type="radio"/> Yes <input type="radio"/> No	Do you have difficulty understanding or speaking English? <input type="radio"/> No <input type="radio"/> Yes,
Do you have a vision impairment: <input type="radio"/> Yes <input type="radio"/> No	If yes, do you have someone who translates for you and can you please provide the name and phone number of translator: _____ _____

In order to fully understand your health care needs, we require information regarding your medical and surgical history.

Please complete the attached Social and Health history forms.

Name: _____ D.O.B. _____



CLIENT SOCIAL AND HEALTH HISTORY

Origin/Culture

1. What is your preferred spoken language: _____
2. What is your preferred written language: _____
3. Do you practice a specific religion, and are there specific religious needs that we should be mindful of in regards to health care: _____
4. Where were you born: _____
If not born in Canada, when did you immigrate: _____
What is your citizenship(s): _____
What culture or ethnicity do you identify with: _____

Education and Occupation

1. What is your highest level of education obtained:
 None Preschool Primary Secondary College University
2. Do you experience any learning difficulties: If so, would you please explain:

3. Can you identify any barriers to learning (i.e. emotional, physical, cultural, language):

4. What is your current occupation: _____ If no occupation, what is the reason: Unable to work Looking for a job Retired /Student
5. Have you ever taken a leave of absence: If so, for what reason: _____
6. If you do not currently have an occupation, what is your source of income:
 Partner Family Ontario Works ODSP WSIB
7. What is your yearly income: _____ Prefer not to answer I don't know
8. How many people are supported on this income: _____

Social Environment

1. What is your relationship status:
 Single In a relationship Common Law Married
 Separated Divorced Widow Remarried
2. Where do you live:
 Private home Apartment Assisted living Nursing home Homeless
3. Have you been homeless or lived in a shelter in the past year: Yes No
4. Are you looking for social housing: Yes No

Name: _____ D.O.B. _____

5. Do you feel you are at risk of eviction/ foreclosure from your home: Yes No

If yes, would you like to explain: _____

6. Household composition:
- | | |
|---|---|
| <input type="radio"/> Couple (no kids) | <input type="radio"/> Mother/Father/ kid(s) |
| <input type="radio"/> Single parent (mom) | <input type="radio"/> Single parent (dad) |
| <input type="radio"/> Extended family | <input type="radio"/> Grand parents / kid(s) |
| <input type="radio"/> Same sex couple | <input type="radio"/> Siblings |
| | <input type="radio"/> Alone |
| | <input type="radio"/> Same sex couple/ kid(s) |
| | <input type="radio"/> Foster parents/ kid(s) |

7. Can you identify any environmental risks where you are living (mold, crime, violence):

8. Do you have a social support network:

- | | |
|--|---|
| <input type="radio"/> Family live nearby | <input type="radio"/> Friends you can contact in a crisis |
| <input type="radio"/> Case worker | <input type="radio"/> Other |

9. What is your sexual orientation:

<input type="radio"/> Straight	<input type="radio"/> Lesbian	<input type="radio"/> Gay
<input type="radio"/> Queer	<input type="radio"/> Trans	<input type="radio"/> Bisexual
<input type="radio"/> Questioning	<input type="radio"/> Two spirited	<input type="radio"/> Prefer not to answer

Social Habits

1. Do you use nicotine products: Yes No

If yes, what kind: Cigarettes Cigars Snuff Chewing Tobacco

If you smoke, how much do you smoke (per day/ per week etc): _____

When did you start smoking: _____

2. If you don't smoke, have you ever smoked: Yes No

If yes: a) When did you start: _____ b) When did you quit: _____

c) How much did you smoke: _____

3. Do you drink alcohol: Yes No

If yes, what kind: Wine Liquor Beer Coolers

4. If you drink, how much do you drink:

a) Per day: _____

b) Per week: _____

c) Per month: _____

d) Socially only: _____

5. If you don't drink now, have you ever drank: Yes No

If yes: a) When did you start: _____

b) When did you quit: _____

c) How much did you drink: _____

6. Do you take other drugs: Yes No

If yes, what kind: Cocaine Marijuana Heroin Other street drugs: _____

7. If you take other drugs, how much do you use

a) Daily: _____ b) Weekly: _____

c) When did you start: _____

Name: _____ D.O.B. _____

8. If you don't use other drugs now, have you ever taken other drugs: Yes No

- If yes:
- a) When did you start: _____
 - b) When did you quit: _____
 - c) How much did you take: _____

9. Are you looking for support for a substance abuse issue? Yes No

If yes, would you like to explain: _____

10. Are you looking for treatment of a mental health condition? Yes No

If yes, would you like to explain: _____

11. Do you take any natural products or remedies: Yes No If yes, what do you take:

Health Care Providers

1. Who is your most recent primary care provider (Dr. Smith, Jane Doe – Nurse Practitioner):

2. Do you see any specialists (Cardiologist, Opthamologist) If so, who and for what:

3. Why are you seeking care at NorWest CHCs:

- I have no primary care provider
- My doctor retired
- I moved, this location is more convenient
- Other: _____

4. If you do not have a primary care provider, where have you been receiving your care (Walk in Clinics, Emergency Department): Please list name of providers and clinics:

5. Do you have immediate family members who are looking for health care: Please list:

NAME	DATE OF BIRTH	RELATIONSHIP

Name: _____ D.O.B. _____

Past Medical History

1. Have you ever had any surgery: Yes No If yes, please describe:

- a) Skin Surgery (ie. mole removal) Date: _____ Surgeon: _____
- b) Neurosurgery (ie. brain) Date: _____ Surgeon: _____
- c) Eye Surgery (ie. cataracts) Date: _____ Surgeon: _____
- d) Ear/Nose/Throat Surgery (ie. tonsils) Date: _____ Surgeon: _____
- e) Dental Surgery (ie. tooth extraction) Date: _____ Surgeon: _____
- f) Facial Surgery (ie. for broken jaw) Date: _____ Surgeon: _____
- g) Chest Surgery (ie. lung) Date: _____ Surgeon: _____
- h) Breast Surgery (ie. masectomy) Date: _____ Surgeon: _____
- i) Heart Surgery (ie. bypass, stents, valve surgery) Date: _____ Surgeon: _____
- j) Stomach or Bowel Surgery (ie. appendix,) Date: _____ Surgeon: _____
- k) Urinary Tract Surgery (ie. kidney, bladder, prostate) Date: _____ Surgeon: _____
- l) Gynecological Surgery (ie. hysterectomy) Date: _____ Surgeon: _____
- m) Orthopaedic Surgery (ie. fracture, replacements) Date: _____ Surgeon: _____
- n) Vascular Surgery (ie. for poor circulation) Date: _____ Surgeon: _____
- o) Plastic Surgery Date: _____ Surgeon: _____
- p) Transplant Surgery Date: _____ Surgeon: _____

2. Have you suffered any major injuries: Yes No If yes, please describe:

3. Do you have any allergies: Yes No If yes, please list:

Medication allergies: _____

What is the reaction: _____

Food allergies: _____

What is the reaction: _____

Environmental allergies: _____

What is the reaction: _____

Name: _____ D.O.B. _____

Do you have any medical conditions, past or present? Please mark those that apply to you:

Heart/Vascular Disease

- None
- Unknown
- Angina
- Aneurysm
- Arrhythmia
- Heart Failure
- Congenital (from birth)

Type: _____

- Pacemaker/Defibrillator
- Heart Attack
- High blood pressure
- High cholesterol
- Other: _____
- Unknown

Skin Disorders

- None
- Eczema
- Psoriasis
- Other: _____

Lung Disease

- None
- Asthma
- COPD
- Tuberculosis
- Other: _____
- Unknown

Breast Disorders

- None
- Cysts
- Pain
- Abnormal mammogram
- Nipple discharge
- Other: _____
- Unknown

Neurologic Disease

- None
- Dementia
- Brain Injury
- Stroke/ Mini Stroke
- Multiple Sclerosis
- Migraines
- Seizures
- Aneurysm
- Other: _____
- Unknown

Ear Nose and Throat

- None
- Hearing loss
- Polyps
- Vocal cord issues
- Recurrent infections
- Other: _____
- Unknown

Renal/Urologic Disease

- None
- Dialysis/Renal Failure
- Enlarged Prostate
- Incontinence
- Urinary tract infections
- Other: _____
- Unknown

Gynecological Disorders

- None
- Menstrual issues
- Menopause
- Sexually Transmitted infections
- Other: _____
- Unknown

Gastrointestinal Disease

- None
- Stomach or Bowel Ulcer
- Polyp
- Irritable Bowel Syndrome
- Crohn's
- Ulcerative Colitis
- Abdominal Aneurysm
- Reflux
- Other: _____
- Unknown

Cancer (- of any kind)

- None
- Type: _____
- When: _____
- Treatment type: _____

Hormone Disease

- None
- Thyroid disease
- Diabetes (o Type 1 o Type 2)
- Infertility issues
- Polycystic Ovarian Syndrome
- Other: _____
- Unknown

Eye Disease

- None
- Glaucoma
- Cataracts
- Blindness
- Diabetic retinopathy
- Other: _____
- Unknown

Psychological Issues

- None
- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- ADHD
- Substance Abuse
- Type: _____
- Other: _____
- Unknown

Musculoskeletal Disease

- None
- Osteoporosis
- Osteoarthritis
- Rheumatoid Arthritis
- Disc Disease
- Gout
- Fibromyalgia
- Chronic Pain
- Cause: _____
- Other: _____
- Unknown

Other Chronic Diseases

- None
- Anemia
- HIV or AIDS
- Blood disorder
- Type: _____
- Hepatitis A, B, or C
- Other: _____
- Unknown

Name: _____ D.O.B. _____

4. Please record the approximate month and year you last had the following tests:

- a) Pap Test _____ / _____
- b) Mammogram _____ / _____
- c) Cholesterol test _____ / _____
- d) Diabetes test _____ / _____
- e) Colon cancer check(Blood in stool test) _____ / _____
- f) Colonoscopy _____ / _____
- g) Prostate exam _____ / _____
- h) Bone Mineral Density Test _____ / _____

5. Please list your current medication name, dose and frequency

Medication Name (ie. Methadone, Metformin, etc.)	Dose (ie. 5 mg, 10 units)	How many times do you take per day Or just when needed

Other Information

1. Do you have any skills or talents you may like to share or teach: Yes No
If yes, what might they be: _____
2. Are you already involved in the community: Yes No
If yes, how: _____
3. Have you volunteered before: Yes No
If yes, how: _____
4. NorWest CHC has a variety of other services available. Please select which may be appropriate to your needs:
 - Therapist Seniors Club Social Worker
 - Dietitian Early Years Programs
 - Seniors Club Diabetes Education
 - Health Education Programs