Waterloo Region Nurse Practitioner Led Clinic
13 Water Street North, Cambridge
123 Pioneer Drive Unit 101, Kitchener
Phone: 519-772-2322
Fax: 519-772-2323
Email: officeadmin@wrnplc.ca

Adult Intake Form

Preferred Location:

☐ Cambridge
☐ Kitchener

First Name:_____**Last Name:**_____**Gender:**_____

Address:_____

Phone number:_____

Date of Birth:_____

Do you have a valid Ontario Health Card? Yes____ No____

Health Card Number and expiry date_____

Do you currently have a family physician?: _____

If not, where have you been getting health care?:_____

Emergency Contact (include name, phone number and relationship):_____
_____

Allergies or Intolerances (Please include type of reaction and onset age**):**
_____
_____

Medical History

Condition	Yes	No
Alcohol/ Drug Use		
Anemia		
Asthma		
Bleeding Problems		
Mental Health Concerns		
Cancer: _____		
Heart Problems		
COPD		

Condition	Yes	No
Diabetes		
Broken Bones		
Hepatitis: _____		
High Blood Pressure		
Migraines/ Headaches		
Stroke		
Thyroid Disease		
Positive TB skin test		

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Other
1.
2.
3.
4.

Do you have any new problems or health concerns that have not been addressed? (Please keep in mind that urgent problems cannot be addressed at the intake session and you should either go to a walk in clinic or emergency if it is urgent)
1._____
2._____
3._____
4._____

SURGERIES

SURGERY and Location	Date of Surgery	Surgeon

ACCIDENTS/INJURIES

Accident/Injury	Date	Intervention

SCREENING

	Pap Smear	Fecal Occult Blood Test	Colonoscopy	Mammogram	Bone Density
Date					
Reason if applicable					
Result					
Location and who performed it					

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MEDICATIONS**If you are on more than 3 medications, please contact your pharmacist and have them fax us a "Medication Check". BRING ALL MEDICATIONS TO FIRST APPOINTMENT**

Medication	Dose	How often	Date Prescribed

HERBALS VITAMINS and OVER THE COUNTER MEDICATIONS

Name	Dose	How often	For what condition

Immunizations **(please bring your immunization records to your appointment)**
When was your last tetanus shot? _____

Do you get the yearly flu shot? ❑**Yes** ❑ **No**
Do you have your records with you? ❑**Yes** ❑ **No**

Have you had the pneumonia shot? ❑**Yes** ❑ **No** when?_____

Have you had the shingles shot? ❑**Yes** ❑ **No** when?_____

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Family History

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
High Blood Pressure								
High Cholesterol								
Heart Attack								
Diabetes								
Stroke								
Bipolar Illness								
Schizophrenia								
Dementia								
Alcoholism								
Depression								
Breast Cancer								
Ovarian Cancer								
Colon cancer								
Prostate Cancer (men only)								
Other: **(**Please define**)**								

Has a family member(s) you indicated above passed away as a result of an illness?

_____

_____

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SOCIAL HISTORY

Alcohol Use
Do you drink alcohol? ❑ No ❑ Yes
# of drinks/week:_____

Caffeine
On average how many caffeinated beverages do you drink a day? _____

Diet
Do you have any dietary requirements/ restrictions?_____

Drug Coverage
❑ None
What Company are you with? _____

Languages
What languages do you speak?
_____
_____

Do you require a translator ❑ Yes ❑ No

Living Arrangements
❑ Alone
❑ A Facility
❑ With family: _____

Occupation:_____

What pharmacy do you use?
_____

Physical Activity
On a daily basis:_____
_____
_____

Recreational Drug use
❑ Yes ❑ No
Explain: _____

Sleep Pattern
On average how many hours do you sleep a night? _____
Do you sleep through the night?
❑ Yes ❑ No

Sexual History
Are you sexually active? ❑ Yes ❑ No

Specialist Care
Are you currently seeing a specialist?
❑ No ❑ Yes
Describe: _____
_____
_____

Spirituality
Do you have any requirements we need to know of? ❑ Yes ❑ No
_____
_____

Stressors
Any particular stressors in your life?
❑ Yes ❑ No
_____
_____

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Tobacco Use
Smoke cigarettes: ❑ Never ❑ No ❑ Yes
Other tobacco:
❑ Pipe ❑ Cigar ❑ Chew
Quit date: _____

How many years did you smoke? _____
Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____
# of years: _____

Women's Health History
Total number of pregnancies: _____
Number of births: _____
Have you ever had an abnormal PAP test?:
_____
_____

What is your Highest Level of Education?_____

Do you have CCAC or homecare services? ❑ Yes ❑ No

How often?_____

What services?_____

Name and number of Care Coordinator

_____

Substitute Decision Maker
Who will make health care decisions for you if you can't (if you become mentally incapable)?

Name(s):_____

Relationship to you:_____

Phone number(s):_____

☐ I don't know/Unsure

Date Completed:_____

Signature:_____

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