Southwest Ontario Aboriginal Health Access Centre

Intake Form

Please complete all appropriate sections

Date (DD/Month/YYYY):_____

1. Basic Demographic Information		
Full Name (First / Middle / Last) (as appears on Health Card)		
Preferred First Name (if different):	Date of Birth (DD/Month/YYYY)	
Marital Status ☐ Common-law ☐ Divorced ☐ Married ☐ Single ☐ Separated ☐ Partner ☐ Widowed		
I would identify myself as: ☐ First Nation (Status) ☐ First Nation (Non-Status) ☐ Métis ☐ Inuit ☐ Other (please identify): _____ My **FN Status Number (Registration Number) or Métis Membership # or Inuit ID Number** is: _____		
Do you identify as a member of the LGBT2Q+ community? ☐ Yes ☐ No ☐ Other: _____		
If you are a person with a Disability **please identify any accommodations** required for your appointment.		
Health Card NO:	Sex:	
Version Code:	Expiry Date:	
2. Address and Contact Information		
Street:	City	Postal Code
Primary Phone #: ☐Mobile ☐ Work ☐Home	Alternate Phone # ☐Mobile ☐ Work ☐Home	
Email Address:		
Preferred means of communication: ☐Mobile ☐ Work ☐Home ☐Text (Consent required) ☐ Email (Consent required)		
Mailing Address (Alternate Address) ☐ same as above or		
Street:	City	Postal Code
Emergency Contact:		
Name:	Relationship:	
Primary Phone #: ☐Mobile ☐ Work ☐Home		
Do you have a Substitute Decision Maker(SDM)/Power of Attorney(POA) for Medical/Personal Care?: ☐ Yes ☐ No Do you have a Substitute Decision Maker(SDM)/Power of Attorney(POA) for Finances/Property?: ☐ Yes ☐ No		
SDM/POA Name:	Relationship:	
Primary Phone #: ☐Mobile ☐ Work ☐Home		

3. Referral Information	
☐ Self / Family / Friend ☐ Justice System ☐Mental Health Services ☐Hospital / Medical Services ☐Other Community Service Agency: _____ ☐ Internal SOAHAC Referral	
Referral Source:	Contact Name:
Phone Number:	Email:

4. If completing forms for child or youth (under 18) Please provide the following information, otherwise continue to section 5.
Legal Guardian (s):
Relationship to child / youth:
Child is Residing with: ☐ Both Parents ☐ Mother ☐ Father ☐ Caregiver ☐ Relative:_____ ☐ Foster Parent(s) ☐ Group Home ☐ Other:_____
Agency Involvement: ☐ CAS/Band Rep ☐ Ontario Works ☐ N'Amerind ☐ SOAHAC ☐ At^Lohsa ☐ Other: _____
If CAS is involved. Please provide the following. Agency Name: Worker(s) assigned to family, include contact information? Identify what type of agreement is in place? ☐ Customary Care ☐ Kinship Care ☐ Foster Care ☐ Temporary Care

4a. Caregiver (Primary) Contact Information		
Full Name (First/Last):		
Street:	City:	Postal Code:
Primary Phone #: ☐Mobile ☐ Work ☐Home	Alternate Phone # ☐Mobile ☐ Work ☐Home	
Relationship:		

4b. Caregiver (Additional) Contact Information		
Full Name (First / Last):		
Street:	City:	Postal Code:
Primary Phone #: ☐Mobile ☐ Work ☐Home	Alternate Phone # ☐Mobile ☐ Work ☐Home	
Relationship:		

4c. Education		
School:	Grade:	School Board:

5. Do you presently have a Family Physician/ Nurse Practitioner? ☐ Yes ☐ No
Provider's Name: _____
Do you presently see a Traditional Healer/Elder? ☐ Yes ☐ No
Healer/Elder's Name: _____
Do you presently see a Mental Health Provider? ☐ Yes ☐ No
Provider's Name: _____

6. I am requesting the following Integrated Wholistic Care Service(s):

- **Traditional Healing**. If yes, please indicate your reason for seeking Traditional Healing Services Care?
  _____
  _____
  ☐Prefer not to answer

- **Mental Health Services for Adults or Children**. If yes, please indicate your reason for seeking Mental Health Services.
  _____
  _____
  ☐Prefer not to answer

- **Clinical Services (including Doctor, Nurse Practitioner, Dietitian, Diabetes Team, FASD, SASH).** If yes, please indicate your reason for seeking Clinical Services.
  _____
  _____
  ☐Prefer not to answer

Please continue on the next page

7. In describing my general well-being

I have the following conditions:

☐ Chronic Illness
☐ Development Disabilities
☐ Drug or Alcohol Dependence
☐ Learning Disability
☐ Mental Illness
☐ Physical Disability
☐ Sensory Disability (i.e. hearing or vision loss)
☐ Other (please specify): _____
☐ None
☐ Do not know ☐ Prefer not to answer

My concerns/conditions include: Check all that apply

☐ Arthritis	☐ Ear/Hearing Problems	☐ Kidney Disease
☐ Asthma or Lung Disease	☐ Eating Problems	☐ Learning Problems
☐ Behavioural Concerns	☐ Eye Problems	☐ Mental health issues
☐ Cancer	☐ Headaches	☐ Pregnancy
☐ Chronic Pain	☐ Heart Disease	☐ Seizures/Epilepsy
☐ Developmental Delays	☐ Hepatitis	☐ Stroke
☐ Diabetes	☐ High blood pressure	☐ Substance Addiction

☐ Other (please specify) :_____

Please list any Medical Specialists, including any complementary health practitioners and what you see them for:

_____

_____

_____

List any known allergies: (food, medicines, environmental, insect) and your reaction.

_____

_____

_____

Medications

Are you using any Traditional Medicines? ☐ Yes ☐ No

Present Medications: ☐ Not currently on medication ☐ Please provide a LIST or CURRENT printout of all medications from your pharmacist. (List any other medications you are taking. Including such items like aspirin, laxatives, vitamins, calcium and other supplements, etc.)

_____

_____

_____

Your Pharmacy (name and address): _____
Pharmacy Phone #: _____
Your Drug Plan:
☐ FNHIB (First Nation Health Insurance Benefit) ☐ Ontario Drug Benefits (ODB) ☐ Private

Narcotics Statement. Please read and initial.

In keeping with SOAHAC's Mission Statement and to assist the clients to improve their quality of health and to live in a more balanced state of well-being, narcotics will be prescribed by the physicians and nurse practitioners (as per regulatory authorization) under certain circumstances (i.e. cancer, palliative care, acute injury).

The physicians and nurse practitioners will work closely with the client and/or their families using an integrated care approach to determine what alternate treatment options are available or should be explored to assist the client (i.e., internal referrals to Traditional Healing, Massage Therapy, Physiotherapy, and Mental Health).

When appropriate, external referrals may be made on behalf of the client to address their pain needs. These referrals will be discussed and agreed upon with the client as appropriate and deemed by the medical professional's clinical judgement.

Initial Here: _____

8. We Ask Because We Care

Ni-gagwe-kendaamin aaniin ezhi-zhiwebiziyin ****** Wetwaliwaʾno:tu'se tsiʾ teyukwate'ha**

Kwchiimoolulóhmwa eél kiiloóna lxawéélumeengw

Additional Information is required for Health Equity, Statistical Purposes and Funding Eligibility. We are collecting social information from clients to find out who we serve and what unique needs our client have. We will also use this information to understand client experiences and outcomes**.**

Do I have to answer these questions?

No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care at SOAHAC.

My nation is:
☐ Cayuga ☐ Cree ☐ Delaware ☐ Inuit ☐ Metis ☐ Mississauga ☐ Mohawk ☐ Odawa
☐ Ojibway / Chippewa ☐ Onondaga ☐ Oneida ☐ Potawatomi ☐ Seneca ☐ Tuscarora
☐ Other (please identify): _____ ☐ Do not know ☐ Prefer not to answer

My Band is:_____

Spiritual identity:
☐ Clan _____ ☐ Do not know ☐ Prefer not to answer
☐ Colour(s) _____ ☐ Do not know ☐ Prefer not to answer
☐ Spirit Name _____ ☐ Do not know ☐ Prefer not to answer
☐ Not applicable ☐ Other _____

Languages spoken at home are:
☐ Cayuga ☐ Cree ☐ English ☐ French ☐ Inuktitut ☐ Lunaapeew ☐ Mohawk ☐ Ojibway ☐ Oneida
☐ Onondaga ☐ Seneca ☐ Tuscarora
☐ Other (please identify): _____

My Community Affiliation (where I reside) is:_____

Describing my family story:

Have you or family members attend Residential School? ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer
Were you or another family member impacted by the 60's Scoop ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

How were you raised? Check all that apply to you:
☐ Birth Family / Family of Origin ☐ Kinship Care / Extended Family ☐ Adopted ☐ Foster Care
☐ Group Home ☐ Other (Please specify) _____ ☐ Do not know ☐ Prefer not to answer

My gender identity is:
☐ Female ☐ Intersex ☐ Male ☐ Trans – Female to Male ☐ Trans – Male to Female
☐ Other (Please specify); _____ ☐ Do not know ☐ Prefer not to answer

My sexual orientation is:
☐ Bisexual ☐ Gay ☐ Heterosexual ("straight") ☐ Lesbian ☐ Queer ☐ Two -Spirit
☐ Other (Please specify) _____ ☐ Do not know ☐ Prefer not to answer

My highest education level attained is:

☐ Primary or equivalent (grades 1 – 8)	☐ No formal education
☐ Secondary or equivalent (Grades 9 – 12)	☐ Other
☐ Post-secondary or equivalent	☐ Do not know
☐ Too young for primary completion	☐ Prefer not to answer

What was your total family income before taxes last year? Check ONE only.

☐ 0 - $14,999	☐ $35,000 to $39,999
☐ $15,000 to $19,999	☐ $40,000 to $59,999
☐ $20,000 to $24,999	☐ $60,000 or more
☐ $25,000 to $29,999	☐ Do not know
☐ $30,000 to $34,999	☐ Prefer not to answer

How many people does this income support?

_____person(s) ☐ Do not know ☐ Prefer not to answer

Who lives in your home?	
☐ Mother father child(ren) ☐ Couple without child ☐ Sole member (I live alone) ☐ Grandparent(s) with grandchild(ren) ☐ Extended family ☐ Unrelated housemates ☐ Siblings	☐ Single parent family (mother head) ☐ Single parent family (father head) ☐ Other ☐ Same Sex Couple ☐ Do not know ☐ Prefer not to answer
What is your living arrangement? ☐ On Reserve ☐ Off Reserve Rural ☐ Off Reserve Urban	
What type of housing?	
☐ Apartment ☐ Group Home ☐ Home Owner ☐ Homeless ☐ Market rental ☐ Other – temporary	☐ Rooming House ☐ Shelter ☐ Subsidized Housing ☐ Do not know ☐ Prefer not to answer

For internal use only.
To be completed by SOAHAC staff (please complete, date and initial)

Have referrals been sent for:
☐ CS ☐ Yes ☐ No ☐ N/A with :_____ Date:_____ Initials: _____
☐ MHA ☐ Yes ☐ No ☐ N/A with :_____ Date:_____ Initials: _____
☐ THS ☐ Yes ☐ No ☐ N/A with :_____ Date:_____ Initials: _____

Intake/First Appointments Booked ☐ Yes☐ No
Chart is created in NOD? ☐ Yes ☐ No Date:_____ Initials:_____

Intake is ☐ Complete ☐ Incomplete? Date:_____ Initials:_____
Intake is ☐ Complete ☐ Incomplete? Date:_____ Initials:_____
Intake is ☐ Complete ☐ Incomplete? Date:_____ Initials:_____

Data entry is complete in NOD? ☐ Yes ☐ No Date:_____ Initials:_____
Data entry is complete in NOD? ☐ Yes ☐ No Date:_____ Initials:_____
Data entry is complete in NOD? ☐ Yes ☐ No Date:_____ Initials:_____

Has the Health Information Consent been entered in NOD as Signature on File with Date?
☐ Yes ☐ No Date:_____ Initials:_____