



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)

**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:**

Band Name (if applicable): \_\_\_\_\_ Band Number (if applicable): \_\_\_\_\_

Live on Reserve: \_\_\_\_\_ If yes, what community: \_\_\_\_\_

☐ Yes ☐ No If no, is the area you live in: ☐ Urban ☐ Rural

Do you identify as a member of the 2SLGBTQ+ 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

SDM/POA Name:

Relationship:

Primary Phone #: ☐ Mobile ☐ Work ☐ Home

|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                               |               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------|
| <b>3. Referral Information</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                               |               |
| <input type="checkbox"/> Self / Family / Friend <input type="checkbox"/> Justice System <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Hospital / Medical Services<br><input type="checkbox"/> Other Community Service Agency: _____ <input type="checkbox"/> Internal SOAHAC Referral                                  |                                                                                                               |               |
| Referral Source:                                                                                                                                                                                                                                                                                                                                  |                                                                                                               | Contact Name: |
| Phone Number:                                                                                                                                                                                                                                                                                                                                     | Email:                                                                                                        |               |
| <b>4. If completing forms for child or youth (under 18) Please provide the following information, otherwise continue to section 5.</b>                                                                                                                                                                                                            |                                                                                                               |               |
| Legal Guardian (s):                                                                                                                                                                                                                                                                                                                               |                                                                                                               |               |
| Relationship to child / youth:                                                                                                                                                                                                                                                                                                                    |                                                                                                               |               |
| Child is Residing with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Caregiver <input type="checkbox"/> Relative: _____<br><input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Group Home <input type="checkbox"/> Other: _____                  |                                                                                                               |               |
| Agency Involvement: <input type="checkbox"/> CAS/Band Rep <input type="checkbox"/> Ontario Works <input type="checkbox"/> N'Amerind <input type="checkbox"/> SOAHAC <input type="checkbox"/> At^Lohsa<br><input type="checkbox"/> Other: _____                                                                                                    |                                                                                                               |               |
| If CAS is involved. Please provide the following.<br>Agency Name:<br>Worker(s) assigned to family, include contact information?<br><br>Identify what type of agreement is in place.<br><input type="checkbox"/> Customary Care <input type="checkbox"/> Kinship Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Temporary Care |                                                                                                               |               |
| <b>4a. Caregiver (Primary) Contact Information</b>                                                                                                                                                                                                                                                                                                |                                                                                                               |               |
| Full Name (First/Last):                                                                                                                                                                                                                                                                                                                           |                                                                                                               |               |
| Street:                                                                                                                                                                                                                                                                                                                                           | City:                                                                                                         | Postal Code:  |
| Primary Phone #: <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home                                                                                                                                                                                                                                      | Alternate Phone # <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home |               |
| Relationship:                                                                                                                                                                                                                                                                                                                                     |                                                                                                               |               |
| <b>4b. Caregiver (Additional) Contact Information</b>                                                                                                                                                                                                                                                                                             |                                                                                                               |               |
| Full Name (First / Last):                                                                                                                                                                                                                                                                                                                         |                                                                                                               |               |
| Street:                                                                                                                                                                                                                                                                                                                                           | City:                                                                                                         | Postal Code:  |
| Primary Phone #: <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home                                                                                                                                                                                                                                      | Alternate Phone # <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home |               |
| Relationship:                                                                                                                                                                                                                                                                                                                                     |                                                                                                               |               |
| <b>4c. Education</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                               |               |
| 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 etc).** If yes, please indicate your reason for seeking Clinical Services.

\_\_\_\_\_  
\_\_\_\_\_

☐ Prefer not to answer

## 7. In describing my general well-being

### My concerns/conditions include: Check all that apply

- |                                                        |                                               |                                               |
|--------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Ear/Hearing Problems | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Asthma or Lung Disease        | <input type="checkbox"/> Eating Problems      | <input type="checkbox"/> Learning Problems    |
| <input type="checkbox"/> Behavioural Concerns          | <input type="checkbox"/> Eye Problems         | <input type="checkbox"/> Mental health issues |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pregnancy            |
| <input type="checkbox"/> Chronic Pain                  | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Seizures/Epilepsy    |
| <input type="checkbox"/> Developmental Delays          | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Substance Addiction  |
| <input type="checkbox"/> Other (please specify): _____ |                                               |                                               |

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

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

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### 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.)

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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 \*\*\*\*\* Wetwaliwa'no:tu'se tsi' teyukwate'ha**

**Kwchiimoolulóhmwa eél kiiloóna lxawéélumeengw**

Additional Information is required better understand the clients we serve. We are collecting this information so we can generate a much-needed pool of accurate information about the health status and needs of the clients and communities we serve.

**Do I have to answer these questions?**

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

***Spiritual identity:***

- |                                            |                                      |                                               |
|--------------------------------------------|--------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Clan _____        | <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Colour(s) _____   | <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Spirit Name _____ | <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Not applicable    | <input type="checkbox"/> Other _____ |                                               |

***What language do you speak most often at home:***

- ☐ English ☐ French ☐ First Nation language (e.g., Mohawk, Anishinaabemowin, Cree, Dene etc.)  
☐ Inuktitut/Inuinnaqtun ☐ Michif ☐ Other: Please specify \_\_\_\_\_

***Do you speak an Aboriginal language or languages?*** ☐ Yes ☐ No ☐ Some ☐ Do not know ☐ Prefer not to answer

**Describing my family story:**

Were you a student at a federal Residential School? ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

Was a family member a student at a federal Residential School? ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

Were you impacted by the 60s 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

**Your gender identity is:**

☐ Female ☐ Intersex ☐ Male ☐ Trans – Female to Male ☐ Trans – Male to Female  
☐ Other (Please specify) \_\_\_\_\_ ☐ Do not know ☐ Prefer not to answer

**Your sexual orientation is:**

☐ Bisexual ☐ Gay ☐ Heterosexual (“straight”) ☐ Lesbian ☐ Queer ☐ Two -Spirit  
☐ Other (Please specify) \_\_\_\_\_ ☐ Do not know ☐ Prefer not to answer

**Do you have any of the following? (Check all that apply)**

|                                                     |                                                 |
|-----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Chronic Illness            | <input type="checkbox"/> Sensory disability     |
| <input type="checkbox"/> Developmental disability   | <input type="checkbox"/> Other (Please specify) |
| <input type="checkbox"/> Drug or alcohol dependence | <input type="checkbox"/> None                   |
| <input type="checkbox"/> Learning disability        | <input type="checkbox"/> Do not know            |
| <input type="checkbox"/> Mental illness             | <input type="checkbox"/> Prefer not to answer   |
| <input type="checkbox"/> Physical disability        |                                                 |

**Your highest education level attained is:**

|                                                                  |                                                  |
|------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Too young for primary completion        | <input type="checkbox"/> University Postgraduate |
| <input type="checkbox"/> Primary or equivalent (grades 1 – 8)    | <input type="checkbox"/> No formal education     |
| <input type="checkbox"/> Secondary or equivalent (Grades 9 – 12) | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> College                                 | <input type="checkbox"/> Do not know             |
| <input type="checkbox"/> University Bachelors                    | <input type="checkbox"/> Prefer not to answer    |

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

|                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> 0 - \$14,999         | <input type="checkbox"/> \$40,000 to \$59,999   |
| <input type="checkbox"/> \$15,000 to \$19,999 | <input type="checkbox"/> \$60,000 to \$89,999   |
| <input type="checkbox"/> \$20,000 to \$24,999 | <input type="checkbox"/> \$90,000 to \$119,999  |
| <input type="checkbox"/> \$25,000 to \$29,999 | <input type="checkbox"/> \$120,000 to \$149,999 |
| <input type="checkbox"/> \$30,000 to \$34,999 | <input type="checkbox"/> \$150,000 and over     |
| <input type="checkbox"/> \$35,000 to \$39,999 | <input type="checkbox"/> Do not know            |
|                                               | <input type="checkbox"/> Prefer not to answer   |

**How many people does this income support?**

\_\_\_\_\_ person(s) ☐ Do not know ☐ Prefer not to answer

|                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Who lives in your home?</b>                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Couple with child(ren)<br><input type="checkbox"/> Couple without child<br><input type="checkbox"/> Single parent family<br><input type="checkbox"/> Grandparent(s) with grandchild(ren)<br><input type="checkbox"/> Extended family | <input type="checkbox"/> Sole member (I live alone)<br><input type="checkbox"/> Siblings<br><input type="checkbox"/> Unrelated housemates<br><input type="checkbox"/> Other<br><input type="checkbox"/> Do not know<br><input type="checkbox"/> Prefer not to answer |
| <b>What type of housing?</b>                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Apartment<br><input type="checkbox"/> Group Home<br><input type="checkbox"/> Homeowner<br><input type="checkbox"/> Homeless<br><input type="checkbox"/> Market rental<br><input type="checkbox"/> Other – temporary                  | <input type="checkbox"/> Rooming House<br><input type="checkbox"/> Shelter<br><input type="checkbox"/> Subsidized Housing<br><input type="checkbox"/> Do not know<br><input type="checkbox"/> Prefer not to answer                                                   |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>For internal use only.</b><br><b>To be completed by SOAHAC staff (please complete, date and initial)</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| Have referrals been sent for:<br><input type="checkbox"/> CS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A with: _____ Date: _____ Initials: _____<br><input type="checkbox"/> MHA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A with: _____ Date: _____ Initials: _____<br><input type="checkbox"/> THS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A with: _____ Date: _____ Initials: _____ |  |
| Intake/First Appointments Booked <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Chart is created in EHR? <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____ Initials: _____                                                                                                                                                                                                                                                                                                          |  |
| Intake is <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete? Date: _____ Initials: _____<br>Intake is <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete? Date: _____ Initials: _____<br>Intake is <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete? Date: _____ Initials: _____                                                                                                                                                                           |  |
| Data entry is complete in EHR? <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____ Initials: _____<br>Data entry is complete in EHR? <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____ Initials: _____<br>Data entry is complete in EHR? <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____ Initials: _____                                                                                                                                             |  |
| Have the Consents been added to the Electronic Health Record?<br><input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____ Initials: _____                                                                                                                                                                                                                                                                                                                                                               |  |
| Has the Integrated Care Intake Checklist been added to the Electronic Health Record?<br><input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____ Initials: _____                                                                                                                                                                                                                                                                                                                                        |  |