Algoma
Nurse Practitioner-Led Clinic

443 Northern Avenue
Sault Ste. Marie, ON
P6B 4J3
Tel: 705-942-4717
Fax: 705-942-9687

Welcome To The Algoma Nurse Practitioner-Led Clinic

You must complete your initial intake or meet and greet appointment with a nurse practitioner for assessment. The nurse practitioner will review your conditions to determine if your needs are compatible with their scope of practice before you are considered a registered/enrolled patient of the clinic. We are not able to refill any medications including narcotics or address any of your medical concerns until after you have you have been accepted as a registered or enrolled patient of the clinic. If you have any urgent concerns, please seek care at Sault Area Hospital or a walk-in-clinic.

I have read and understand this. **Please initial in the box** ☐

Patient Registration & Questionnaire Form

Last Name

First Name

Date Of Birth (DD/MM/YYYY)

Identified Gender

Ohip Number

Expiry Date

Main Phone Number

Alternate Phone Number

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Street Address

Apartment/Unit Number

Town/City | Province | Postal Code

Phone Number | Email Address

Emergency Contact Name

Emergency Contact Phone Number | Releationship To You

Name & Location Of Previous Provider _____

Where Have You Been Receiving
Care In The Past Five (5) Years? _____

When Was The Last Time You Visited A
Health Care Provider & Who Did You See? _____

Which Pharmacy Do You Use? (Name And Location) _____

Do You Currently Have Drug Coverage? Yes ☐ No ☐

If Yes, Through Which Company? _____

Highest Level Of Education _____

Occupation _____ Employer _____

Do You Live In A Group, Retirement Or Long-Term Care Home? Yes ☐ No ☐

If Yes, Which One? _____

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What Languages Do You Speak? _____

Do You Have Any Allergies/Intolerances? Yes ☐ No ☐

If Yes Please List Allergen And Reaction Below: (Please Include Medication, Latex, Enviromental, Etc.)

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Immunizations

Flu	Date
Gardasil (HPV Vaccine)	Date
Hepatitis A	Date
Hepatitis B	Date
MMR (Measles, Mumps, Rubella)	Date
Pneumococcal	Date
Shingles Vaccine	Date
TB Skin Test; Positive ☐ Negative ☐	Date
Tetanus, Diphtheria – With ☐ Without ☐ Whooping Cough	Date
Twinrix	Date
Varicella	Date
COVID-19: ☐ Pfizer-BioNTech ☐ Moderna	Date
☐ Johnson & Johnson ☐ AstraZeneca	Date
Other	Date

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Family Health History

Family Member	Living (L) Deceased (D)* Unknown (U)	Medical Condition (Examples; Diabetes Mellitus, Cancer & Type; High Blood Pressure; Heart Attack; Stroke, Etc. Please Include Age @ Diagnosis If Known)
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		

Have You Been Hospitalized In The Past 2 Years? Yes ☐ No ☐

Personal Medical History (Please Check Any That Apply)

	Year Diagnosed		Year Diagnosed		Year Diagnosed
☐ Acid Reflux	_____	☐ Osteoporosis	_____	☐ Diabetes	_____
☐ Heart Attack	_____	☐ Bipolar Disorder	_____	☐ Sleep Apnea	_____
☐ Alcoholism	_____	☐ Osteoarthritis	_____	☐ Drug Addiction	_____
☐ Kidney Disease	_____	☐ Blood Clots	_____	☐ Stroke	_____
☐ Anemia	_____	☐ Peripheral Vascular Disease	_____	☐ Eczema	_____
☐ Liver Disease	_____	☐ Bulemia	_____	☐ Thyroid	_____
☐ Anorexia	_____	☐ Prostate Issues	_____	☐ Hepatitis	_____
☐ Lupus	_____	☐ Cancer	_____	☐ Ulcers Of Stomach	_____
☐ Anxiety	_____	☐ PTSD	_____	☐ HIV	_____
☐ Migraine	_____	☐ COPD	_____	☐ High Blood Pressure	_____
☐ Asthma	_____	☐ Schizophrenia	_____	☐ High Cholesterol	_____
☐ Mumps	_____	☐ Congestive Heart Failure	_____	☐ Other:	_____
☐ Atrial Fibrillation	_____	☐ Seizures	_____	☐ Other:	_____
☐ Obesity	_____	☐ Depression	_____		
☐ Bell's Palsy	_____	☐ Sexually Transmitted Disease	_____		

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Have You Had Any Past Injuries/Fractures?	Year

Have You Had Any Past Surgeries?	Year

Mental Health

Over the last month, have you gotten less pleasure from things you used to enjoy? Yes ☐ No ☐

Over the last month, have you been feeling sad or blue? Yes ☐ No ☐

Do You Have A History Of:

Abuse	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Addiction	Yes ☐	No ☐
Grief/Trauma (loss/accident)	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐
Schizophrenia	Yes ☐	No ☐

Have You Ever Been Seen For Or Are Concerned About:

A Learning Disability	Yes ☐	No ☐
A.D.D	Yes ☐	No ☐
Fetal Alcohol	Yes ☐	No ☐
A.D.H.D	Yes ☐	No ☐

Would You Be Interested In The Following Services:

Counselling Yes ☐ No ☐ Parenting Support Yes ☐ No ☐

Referrals Yes ☐ No ☐ Support With Other Social Services Yes ☐ No ☐

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Medications & Supplements

Please contact your pharmacy to request an ACTIVE medication list printout and attach it to this form.
Please also list any supplements or OTC medications you are taking below.

_____

_____

_____

Lifestyle

How Physically Active Are You? Not ☐ 1-2x Per Week ☐ 3-4x Per Week ☐ 5-7x Per Week ☐

Do You Have Any Special Dietary Needs? Yes ☐ No ☐

If Yes, What? _____

Do You Drink Caffeinated Beverages? (Ie: Tea, Cola, Coffee) Yes ☐ No ☐

If Yes, How Many Per Day? _____

Do You Consume Alcohol? Yes ☐ No ☐

If Yes, How Many Standard Drinks Per Day? _____
(Ie. 12 Oz Beer/ 1.5 Oz Shot Of 40% Liquor/ 5 Oz Wine = 1 Standard Drink)

Do You Consume Cannabis? Medical ☐ Recreational ☐ Frequency _____ Amount _____

Smoking Status

Non-Smoker ☐ Current Smoker ☐ Ex-Smoker ☐ Vape ☐

If Current, How Many Cigarettes Per Day? _____

Year Started Smoking _____ Year Quit Smoking _____

Do You Use Chewing Tobacco? Yes ☐ No ☐ Drug Use (Recreational) Yes ☐ No ☐

If Yes, What And How Often? _____

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For Women Only

Regular Menstrual Cycle Yes ☐ No ☐

Spotting Yes ☐ No ☐

Pre-Menstrual Dysphoric Disorder Yes ☐ No ☐

Currently Using Birth Control Yes ☐ No ☐

Do You Have An OBGYN? Yes ☐ No ☐

If Yes, Who? _____

Number of Pregnancies _____

Number of Births _____

Number of Abortions _____

Number of Miscarriages _____

Postmenopausal Yes ☐ No ☐

If Yes, Year? _____

Are You Interested In Preconception Planning? Yes ☐ No ☐

Are You Planning To Have A Baby In The Near Future? Yes ☐ No ☐

Year of Last	Year	Result	
PAP		Normal ☐	Abnormal ☐
Breast Exam		Normal ☐	Abnormal ☐
Mammogram		Normal ☐	Abnormal ☐
Bone Density		Normal ☐	Abnormal ☐
FOBT		Normal ☐	Abnormal ☐
Colonoscopy		Normal ☐	Abnormal ☐

For Men Only

Year of Last	Year	Result	
FOBT		Normal ☐	Abnormal ☐
Colonoscopy		Normal ☐	Abnormal ☐
BMD (Bone Density)		Normal ☐	Abnormal ☐

Any Other Information You Think Is Important For Us To Know: _____

How Did You Hear About Us? _____

I confirm the information I have provided in this form to be complete, truthful and accurate. Please initial in the box. ☐

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Consent To The Collection, Use And Disclosure Of Personal Health Information

I, _____ understand that the Algoma Nurse Practitioner-Led Clinic (NPLC) is seeking my consent to collect, use and disclose my personal health for the purpose of providing primary care services. It is understood that when attending Ministry of Health and Long Term Care funded services, there will be a requirement of submitting some information regarding service usage to the ministry.

I understand that the Algoma NPLC will only collect, use and disclose my personal health information with my consent unless a particular collection, use or disclosure is permitted or required by law without my consent.

This consent includes permission for the Algoma NPLC to contact Health Care Connect on my behalf to verify my enrolment in the program. With my permission and successful registration with the NPLC, they may remove my name from the Health Care Connect program.

The Algoma NPLC takes your privacy seriously. All employees have signed a confidentiality agreement permitting them to access your personal and health information only when required for the provision of health services. Your personal and health information will only be shared with agencies outside of the clinic with your informed consent, when not directly pertaining to the provision of health services unless specifically allowed by law. Permission to share your information can be revoked by you at any time, in writing to the Algoma NPLC. The Algoma NPLC has a comprehensive privacy policy available for viewing upon your request.

I hereby authorize the Algoma NPLC to collect, use and disclose my personal health information for the purposes indicated above.

☐ I have read and understand the terms above

Name of Patient	Signature	Date
Witness	Signature	Date

If you are filling this form out on behalf of someone, please sign below:

Name of Guardian/ Decision-Maker	Signature	Date