New Client Intake/Referral Form

Name: _____ **Today's Date:** _____
mm dd yyyy

Health Card #: _____ **Version**: _____ **Date of Birth**: _____
mm dd yyyy

Address: _____

City: _____ **Province**: _____ **Postal Code:** _____

Phone Number: (____) _____-_____ **Alternate Number:** (____) _____-_____

Instructions for Contacting Client: _____

Emergency Contact (include Phone #): _____

Referred by: ☐ **Self** ☐ **CMHA Worker** _____ ☐ **Other** _____

Please check one:

☐ I do not have a family doctor or nurse practitioner

☐ I currently have a family doctor or nurse practitioner but am looking to switch to CMHA Health Centre

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CMHA Health Centre Address: 1400 Windsor Ave., Windsor, Ontario N8X 3L9
CMHA Health Centre Tel: (519) 971-0116 • CMHA Health Centre Fax: (519) 252-5646

CMHA Health Centre

HEALTH SCREENING FORM
(Completed by client)

Name:_____ **Today's Date:** _____

GENDER:

- ☐ Male
- ☐ Female
- ☐ Transgender (M-F , F-M)
- ☐ Two-Spirit
- ☐ Other
- ☐ Prefer not to answer
- ☐ Intersex

SEXUAL ORIENTATION:

- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Queer
- ☐ Two-Spirit
- ☐ Other_____
- ☐ Do not know
- ☐ Prefer not to answer

RACIAL OR ETHNIC GROUP

- ☐ Asian (South/East/South East)
- ☐ Latin American
- ☐ First Nations
- ☐ White (European/North American)
- ☐ Indian-Caribbean
- ☐ Aboriginal/Indigenous
- ☐ Metis
- ☐ Middle Eastern
- ☐ Inuit
- ☐ Prefer not to say
- ☐ Mixed Heritage
- ☐ Other _____
- ☐ Black (African/Caribbean/North American)

ANNUAL INCOME:		
$0 - $14,999 ☐	$15,000 - $19,000 ☐	$20,000 - $24,999 ☐
$25,000 - $29,999 ☐	$30,000 - $34,999 ☐	$35,000 - $39,999 ☐
$40,000 - $59,999 ☐	$60,000 or greater ☐	ODSP / OW ☐
I don't know ☐	Prefer not to answer ☐	☐ ☐

What medications are you taking *(including over the counter products, vitamins, products from health food store or drug store, etc. taken on a regular basis)*? **Please bring all medications with you on your first visit**

Name	Dose	How often?		Name	Dose	How Often?

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Please list any drug allergies **and the reaction** that you had to the drug.

Drug	Reaction		Drug	Reaction

FAMILY HISTORY

Does/did anyone in your family have any of the following conditions?

Condition	Yes	No	Age at diagnosis/Type
Breast Cancer	☐	☐	_____
Colon Cancer	☐	☐	_____
Prostate Cancer	☐	☐	_____
Other Cancer	☐	☐	_____
High Cholesterol	☐	☐	_____
Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____
Depression/Anxiety/Other	☐	☐	_____
Other conditions	☐	☐	_____

LIFESTYLE HISTORY

Have you ever smoked tobacco?

Yes ☐ No ☐

If yes, how many cigarettes? _____ per day for_____years.

Do you smoke cannabis?

Yes ☐ No ☐

If yes, how many/much? _____

Do you drink alcohol?

Yes ☐ No ☐

If yes, how many drinks a day? _____

Are your immunizations up to date?

Yes ☐ No ☐ Don't know ☐

Have you ever taken illegal drugs? Please List _____.

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MEDICAL HEALTH HISTORY

1. Have you ever had or been told you had any of the following conditions?:

Condition	Yes	No	Condition	Yes	No
Epilepsy/seizures	☐	☐	Bowel Disease	☐	☐
Fainting spells or dizziness	☐	☐	Diabetes	☐	☐
Headaches	☐	☐	Ulcers/vomiting blood	☐	☐
Backache/Neck ache, injury to back or neck	☐	☐	Gall bladder disease	☐	☐
High Blood pressure	☐	☐	Liver disease/hepatitis/jaundice	☐	☐
Arthritis, rheumatism	☐	☐	Cancer | Type:	☐	☐
Heart murmur	☐	☐	Sexually transmitted disease	☐	☐
Heart attack, angina, chest pain	☐	☐	Alcoholism or addiction	☐	☐
Other heart problems	☐	☐	Hemorrhoids/rectal bleeding	☐	☐
Difficulty in breathing/shortness of breath	☐	☐	Emotional/Psychiatric illness	☐	☐
Asthma	☐	☐	Hearing problems	☐	☐
Emphysema	☐	☐	Anemia or blood disorder	☐	☐
Tuberculosis	☐	☐	Foot Problems	☐	☐
Eczema, skin problems, hives	☐	☐	Eye problems (other than needing glasses)	☐	☐
Kidney or bladder trouble	☐	☐	Other Chronic Pain_____		

Other: _____

WELLBEING QUESTIONS:

1. How would you describe your sense of belonging to your community? (Sense of belonging is feeling like you are a part of something, connected and accepted)
   ☐ Very Weak ☐ Somewhat Weak ☐ Somewhat Strong ☐ Very Strong

2. In general, would you say your overall physical health is:
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

3. In general, would you say your overall mental health is:
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

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