GIIWEDNO MSHKIKIIWGAMIG

Intake Form

Please complete all appropriate sections

Date (DD/Month/YYYY):_____

1. Basic Demographic Information	
Full Name (First/Middle/Last) as it appears on Health Card	
Preferred First Name:	Date of Birth (Day/Month/Year)
Are you: ☐ Female ☐ Male ☐ Transgender ☐ Other (please identify): _____Pronouns:_____	
Do you identify as a member of the 2S-LGBT2Q+ community? ☐ Yes ☐ No ☐ Other:	
Do you have a health card (OHIP)? ☐ Yes ☐ No ☐ In Process If yes, health card #_____ Version Code: _____ Expiry Date: _____ Sex Identified on Health Card: ☐M ☐ F ☐ X	
Marital Status ☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Partner ☐ Widow/er	
Identifies 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: _____My community: _____ **SELF-IDENTIFICATION** **The North Bay Indigenous Hub receives funding from the Ministry of Health and Long-Term Care's Primary Health Branch to support the Indigenous community at the clinic. Please note that this funding is specifically given to support the Indigenous community ONLY (First Nation, Metis and Inuit). If you are submitting an intake for consideration at the North Bay Indigenous Hub, please note that we have the right to request proof of ancestry (i.e. membership of First Nation or Metis Nation). This is to mitigate the risk of accepting intakes with false or exaggerated connection to Indigenous identity and service ONLY those who meet the criteria.**	
If you are a person with a disability, **please identify any accommodations** required for your appointment:	

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: ☐ Cell ☐ Work ☐ Home ☐ Text (consent required) ☐ Email (consent required) ☐ Consent obtained (verbal/written)		
Mailing Address (Alternate Address) ☐ Same as above or other		
Street	City	Postal Code

3. Emergency Contact Information	
Name and 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 and Relationship:	Primary Phone #: ☐ Mobile ☐ Work ☐ Home
4. Referral Information	
☐ Self/Family/Friend ☐ Justice System ☐ Mental Health Services ☐ Hospital / MedicalServices Other Community Service Agency: ☐ Internal Referral:	
Reason for Referral:	
Referral Source:	Contact Name:
Primary Phone #: ☐ Mobile ☐ Work ☐ Home	Email Address:
5. If completing forms for child or youth (under 18) Please provide the following information, otherwise continue to section 6	
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: ☐ Child Welfare ☐ HANDS ☐ One Kids' Place ☐ Other: _____ Service received: _____ If Child Welfare Services is involved, please provide the following: Agency name: _____ Worker(s) Assigned to the family, including contact information: _____ _____ Please identify what type of agreement is in place: ☐Customary Care ☐Kinship Care ☐Foster Care ☐Temporary Care ☐Other:_____	

5a. Caregiver (Primary) Contact Information		
Name and Relationship	Primary Phone #: ☐ Mobile ☐ Work ☐ Home	
Street	City	Postal Code
5b. Caregiver (Additional) Contact Information		
Name and Relationship	Primary Phone #: ☐ Mobile ☐ Work ☐ Home	
Street	City	Postal Code

5c. Education		
School	Grade	School Board

6. Current Practitioner (if applicable)
Do you presently have a Family Physician/Nurse Practitioner? ☐ Yes ☐ No If yes, please indicate why you would like to transfer to the North Bay Indigenous Hub: Provider's Name: _____
Do you presently see a Traditional Healer/Elder? ☐ Yes ☐ No Healer/Elder's Name: _____
Do you presently receive counselling and/or outreach services? ☐ Yes ☐ No Provider's Name: _____

7. Request for Integrated Wholistic Care Service(s)	
☐ Clinical services – Nurse Practitioner/Physician ☐ Care Coordination ☐ RN Maternal, Child and Sexual Health ☐ Dietitian ☐ Social Work ☐ Traditional Healing ☐ Mental Health and Wellness (including addictions support) ☐ Physical Wellness ☐ Two-Spirit Outreach	**PLEASE list ONE service as your priority you would like to access first and reason for the request:

8. Your General Well-Being	
I have the following conditions: ☐ Behavioural conditions ☐ Chronic Illness ☐ Developmental Disabilities ☐ Drug/Alcohol Dependence ☐ Learning Disability ☐ Mental Illness ☐ Physical Disability	☐ Sensory Disability (i.e., hearing or vision loss) ☐ Trauma/PTSD ☐ Other (Please specify): _____ ☐ None ☐ Do not know ☐ Prefer not to answer

My concerns/condition include:
(Please check all that apply)

- ☐ Arthritis
- ☐ Asthma/COPD/Lung disease
- ☐ Behavioural concerns
- ☐ Breastfeeding
- ☐ Cancer, or history of
- ☐ Chronic Pain
- ☐ Developmental Delays/Global delays
- ☐ Diabetes
- ☐ Ear/Hearing issues
- ☐ Eating disorder/issues
- ☐ Eye problems
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Learning differences
- ☐ Mental Health issues
- ☐ Pregnancy
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Substance Use/Addiction
- ☐ Other (Please specify):

_____
_____
_____

Please list any Medical Specialists, including any complementary health practitioners and the reason you see them:

_____
_____
_____

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

_____
_____
_____

9. Medications

Are you using any Traditional Medicines? ☐ Yes ☐ No
If yes, please list: _____
_____

Present Medications:

☐ Not currently taking medications

☐ Please LIST or provide a CURRENT printout of all medications from your pharmacist (List all medications such as vitamins, herbal or other supplements, aspirin, etc.):

_____
_____
_____

What pharmacy do you use? (name and address): _____
Pharmacy phone #: _____
Your current health/drug benefits:

☐ FNHIB (First Nation Health Insurance Benefit)
☐ NIHB (Non-Insured Health Benefit)
☐ Ontario Drug Benefits (i.e. Trillium) ☐ Private ☐ None

We Ask Because We Care! We Want to Improve Your Service!

Additional information is asked to better understand the individuals, families and communities we serve. Your response will help to serve our current and future population base to ensure services are delivered with high quality care specific to addressing the needs of our clients. Information will be used to understand client experiences and to improve health outcomes.
**You do not have to answer these questions. They are voluntary and you can select "prefer not to answer" to any or all questions. This will not affect your care or services you receive at the North Bay Indigenous Hub.

What language do you speak most often at home?
☐ English ☐ French ☐ First Nation language (e.g., Anishinaabemowin, Cree, Dene, etc.)
☐ Inuktitut/Inuinnaqtun ☐ Michif ☐ Other (please identify): _____
☐ Prefer not to answer

Do you speak an Indigenous language/languages? ☐ Yes ☐ No ☐ Some ☐ Prefer not to answer

Describe your family story:
Were you a student at a Residential School? ☐ Yes ☐ No ☐ Prefer not to answer
Was a family member a student at a Residential School? ☐ Yes ☐ No ☐ Prefer not to answer
Were you impacted by the 60s scoop? ☐ Yes ☐ No ☐ Prefer not to answer

How were you 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
raised? (Check all that apply to you):

Present family composition (check all that apply):
☐ Single ☐ Single Parent (Mother) ☐ Single Parent (Father) ☐ Couple without children ☐ Couple with children
☐ Grandparents w/children ☐ Other (please specify) _____ ☐ Prefer not to answer

Are you:
☐ Female ☐ Male ☐ Intersex ☐ Trans-Female to Male ☐ Trans-Male to Female
☐ Other (Please specify) _____ ☐ Do not know □ Prefer not to answer

Sexual Orientation
☐ Heterosexual ("straight") ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐ Two-Spirit
☐ Other (Please specify) _____ ☐ Do not know ☐ Prefer not to answer
Are you: ☐ Monogamous ☐ Non-Monogamous

Social History (check all that apply):
What is your average weekly alcohol consumption? ☐ None ☐ Only during Social Events
Weekly (average) amount? _____ ☐ Prefer not to answer
Tobacco Use (check which applies) ☐ Never a smoker ☐ Former Smoker ☐ Light Smoker
☐ Heavy Smoker ☐ Prefer not to answer

Highest education level attained:	
☐ Too young for primary completion ☐ Primary or equivalent (grades 1—8) ☐ Secondary or equivalent (grades 9—12) ☐ College ☐ College graduate/post graduate ☐ University – □ Undergraduate □ Graduate	☐ University graduate/post graduate ☐ No formal education ☐ Other ☐ Do not know ☐ Prefer not to answer
What was your total family income before taxes last year?	
☐ 0 - $14,999 ☐ $15,000 to $19,999 ☐ $20,000 to $24,999 ☐ $25,000 to $29,999 ☐ $30,000 to $34,999	☐ $35,000 to $39,999 ☐ $40,000 to $59,999 ☐ $60,000 or more ☐ Do not know ☐ 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?	
☐ Couple with child(ren) ☐ Couple without child ☐ Single parent family ☐ Grandparent(s) with grandchild(ren) ☐ Extended family ☐ Foster children	☐ Sole member (I live alone) ☐ Siblings ☐ Unrelated housemates ☐ Other ☐ Do not know ☐ Prefer not to answer

Updated: April 24, 2023

For internal use only. To be completed by North Bay Indigenous Hub intake staff (please complete, date and initial)	
Intake completed by:	Date (MM/DD/YYYY):

Occasionally, we are contacted by HealthCare Connect in order to find you the first available health care provider. By applying here, you are NOT automatically registered with HealthCare Connect. To do so, please call 1-800-445-1822 or www.healthcareconnect.com

Furthermore, information on this form will not be shared with anyone who is not part of the North Bay Indigenous Hub Primary Healthcare Team without your permission. Please fax, mail or deliver this application to:

North Bay Indigenous Hub
Satellite Office
1040 Brookes Street
North Bay, ON P1B 2N6
Tel: (705) 995-0060
1-888-959-2062
Confidential Fax: (705) 995-2155

**Please note we are not accepting completed Intake Forms sent through email. The completed Intakes must be sent via our confidential fax#, Canada post or hand delivered to the NBIH mailbox. Miigwech.