LAICHWILTACH
COMMUNITY HEALTH CENTRE

PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of the Laichwiltach Community Health Centre. This form is used to collect information about new patients and is used for internal purposes only. The information you supply is confidential and will be treated accordingly. Laichwiltach Community Health Centre provides a multidisciplinary, holistic, wrap-around approach to health care and as such pertinent information may be shared only amongst your care team providers as necessary. If you are unable to complete this form independently, your care provider will complete this in collaboration with you.

Patient Information	
Full Legal Name:	
Preferred Name:	
Date of Birth:	Gender:
Address:	City:
Province:	Postal Code:
Phone:	Personal Health Number:
Email Address:	Date:
Ancestry/Culture:	Identify as First Nations, Metis, or Inuit?
Status ☐ Non-Status ☐ Status #:	If known, name of Nation/Community:

Emergency Contact		
Name	**Relationship**	**Phone number**

Medical History		
Please indicate if you have experienced any past/current medical problems listed below:		
ANEMIA	DIABETES	KIDNEY DISEASE
ARTHRITIS	HYPERTENSION	MENOPAUSE
ASTHMA	DEPRESSION/ANXIETY	MIGRAINES/HEADACHES
ATRIAL FIBRILLATION	FIBROMYALGIA	EPILEPSY
CHEST PAIN	STOMACH CONDITIONS	STROKE
CONGESTIVE HEART FAILURE	HEART DISEASE	HIV
CANCER	HEP A/HEP B/ HEP C	THYROID DISEASE
OTHER	OTHER	OTHER

Family Medical History		
Relative	**Condition**	**If deceased, at what age?**
Father		
Mother		
Sibling		
Other		
Other		

Surgical History			
Description	**Surgeon**	**Location**	**Year**

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