New Patient Intake Form
Date: _____

KINDRED
CARE COLLECTIVE
www.kindredcaresk.ca | (306) 634-6444

Name:		
DOB:	Age:	Gender:
Address:		
Phone #:	Email:	
Health Card Number:		
Allergies:		
Pharmacy:	Specialists / Other providers:	

Past Medical History - please indicate all applicable answers

Cardiac	Heart Attack Stents or bypass surgery Valve replacements Heart Failure Other:_____	High blood pressure Low blood pressure Atrial Fibrillation (Afib) Pacemaker/Defibrillator
Respiratory	COPD / Emphysema Asthma Tuberculosis Pneumonia (frequent) Other: _____	Sleep apnea Home oxygen Shortness of Breath Pulmonary Embolism (clot in lungs)
Circulatory	Blood or clotting disorder Stroke High cholesterol Anemia Other:	Varicose Veins Leg Cramps Swelling in legs DVT (clot in legs)
Gastrointestinal	Acid Reflux/GERD Hernia (location:_____) Gall stones Liver disease Crohns or Collitis Inflammatory bowel disease Stomach Ulcer Other:_____	Hemorrhoids Rectal Bleeding Ostomy Bowel obstructions Constipation Diarrhea

Genitourinary	Kidney disease Kidney failure Frequent UTIs PCOS Endometriosis Other:_____	Catheter Nephrostomy Prolapse Enlarged Prostate Sexually Transmitted infections
EENT	Cataracts Glacoma Blind Hard of Hearing Other:	Macular degeneration Other vision problems Diabetic retinopathy Ringing in the ears Nasal polyps
Metabolic/Endocrine	Diabetes - Type 1 or Type 2 Thyroid - hyper(↑) or hypo (↓) Other:	
Neurological	Stroke Seizures / epilepsy Dementia or Alzheimers Memory loss Brain Injury Parkinson's Other:	Syncope (fainting) Dizziness Neuropathy Multiple Sclerosis Tremors Migranes
Mental Health / Neurodevelopmental disorders	Depression Anxiety Bipolar disorder Schizophrenia Learning disability (specify) Other:	Postpartum Depression Autism ADHD PTSD Asbergers
Other history	Autoimmune disorder(s): Cancer(s) specify location + date(s):	
If applicable:	Number of pregnancies: Number of children: C-section?	Hysterectomy Tubal Ligation Menopausal (or Peri) IUD? Insertion Year of IUD:
Musculoskeletal	Broken bones, specify: Osteoarthritis Rheumatoid arthritis Bone / Joint pain - specify location(s)	Weakness Recent Falls Back pain Amputation or prosthesis Other:

Surgical History	Please include surgery and approx. date(s)/years(s)
Family history	List any significant family history of disease(s) of first degree relatives (mom/dad/sister/brother)

Please list any current medications you take and their frequency (daily, twice a day, etc.)	
Do you drink alcohol?	Yes____ no_____ Amount per week _____
Do you smoke / vape?	Yes____ no_____ Pack / amount per day _____
Do you use marijuana?	Yes____ no_____ Frequency /amount _____
Do you use any other substances?	

Do you have any immediate or pressing concerns you want to discuss?	

Immunization History - include date(s)/years if able

Have you had all your routine childhood immunizations?	Yes____ No_____ Ongoing___ Unsure___
Pneumonia Vaccine	
Shingles vaccine	
Tetanus vaccine within the last 10 years?	
Other vaccinations: travel related, HPV, RSV, etc.	

Routine Health Screening - include date(s)/years if able

Exam / Test	Month / Year
PAP smear (if applicable)	
Mammogram (if applicable)	
Colonoscopy	
Colorectal screening (FIT tests)	
Annual physical / bloodwork	
Prostate Exam / PSA (if applicable)	
STI screening	

I confirm the information provided is accurate to the best of my knowledge.	
Signature:	Date: