



Intake Application for AHWS Community Family Healing Program

Date of Application: _____ Program Date: _____

1. Participants information

Last Name: _____

First Name, Middle Initial: _____

Address: _____

D.O.B: _____ Community/First Nation _____

Phone: _____ Email: _____

In Case of Emergency Contact Name _____

Relationship to participant _____ Phone: _____

Mailing address: _____

2. How did you find out about this program

Person/Worker _____ Phone: _____

Referring Agency/Organization _____

3. Reason for Application

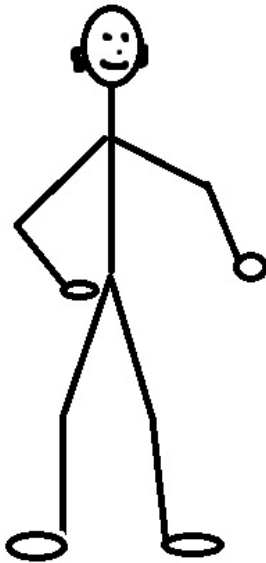
Please describe briefly the reasons or situation that caused you to apply for services with the Community Healing Program.

4. PLEASE INDICATE ANY AND ALL ISSUES AFFECTING FAMILY.

Physical Health Survey

Do you have Heart Trouble or coronary? Y N	How many hours do you sleep at NIGHT? _____
History of Heart Problems in the Family? Y N	How often do you see a doctor?
Do you have a history of High Blood Pressure? Y N	Do you exercise regularly? How often?
Do you have Diabetes, type 1 ___ type 2 ___	Do you have body weight issues you would like to address? Y N
Do you have high cholesterol? Y N	Do you smoke? Y N
Do you have trouble sleeping? Y N	How many cups of caffeine do you drink?
Do you have recurring headaches? Y N	Are you pregnant?
How frequent are the headaches <small>daily, hourly, weekly</small>	Do you have any food allergies?
How much water do you drink a day?	Are you taking any medications? Y N type _____

Where you are experiencing any pain?



Signature: _____

Date: _____

Witness: _____

All information collect is confidential and will be collected by the Community Healing program, Sioux Lookout First Nations Health Authority. If you would like referrals to Nodin CFI it will be a separate process.