Main Office
233 S Court St, 1st Floor
Thunder Bay, ON P7B 2X9
Tel: (807) 344-4575
Toll Free: 1-833-625-3611
Fax: (807) 346-2371

Clinic Site
101 Syndicate Ave N, Suite 510A
Thunder Bay, ON P7C 3V4
Tel: (807) 346-2370
Toll Free: 1-833-625-3611
Fax: (807) 346-2371

Matawa Health Co-Operative Patient Application Form

Last Name:	First Name:	Preferred Name:
Sex at Birth: Female ☐ Male ☐	Date of Birth:	First Nation: (if Applicable)
Health Card Number:	Phone Number/E-mail:	Status Number:
Address:		
City/Town/Village:	Province:	Postal Code:
Emergency Contact Name:	Emergency Contact Phone Number:	Relationship:
Do you have a current Primary Care Provider: (Includes a Nurse Practitioner or Physician)		Are you an Employee of Matawa:

Social History

Relationship Status: Single ☐ Dating ☐ Common-Law ☐ Married ☐ Prefer not to say ☐

Name of Spouse/Partner:

Employment Status: Employed ☐ ODSP ☐ OW ☐ Student ☐ Retired ☐ Volunteer ☐

Do you use traditional medicine? Yes ☐ No ☐ If No, would you be interested? Yes ☐ No☐

Are you seeking or participating in treatment for substance abuse? Yes ☐ No ☐

Medical History

Pharmacy Name:	Location:	Phone Number:

Do you consent to obtaining your medication list from the above pharmacy before your initial appointment? Yes ☐ No☐

Medication List (include over the counter, Traditional and natural medicines). **Must** be attached:

Medications	Reason for taking

Do you have any allergies ? Yes ☐ No ☐

Have you ever been admitted or transported to the hospital ? Yes ☐ No ☐

Have you had any surgeries ? Yes ☐ No ☐	
Do you access any other clinics or specialists ? Yes ☐ No ☐	Clinic/Specialist Name:
Previous Care Provider/Family Physician:	Phone Number:
Address:	

Family History

Please check all that apply:

Diabetes ☐ Blood Disorder ☐ High Cholesterol ☐ Stomach Issues ☐ Bone/Joint Disorders ☐ Addictions☐ Kidney Disease☐

HIV/AIDS ☐ Heart Disease ☐ Eating Disorder ☐ Stroke ☐ Chronic Headaches ☐ Thyroid Disorder☐ Skin Disorders☐

Asthma/COPD ☐ Depression/Anxiety ☐ Arthritis ☐ Cancer ☐Type:____________________ Other ☐______________________

**** The initial appointment is for introductions and gathering information about your health care needs. Forms such as WSIB, ODSP, Special Diets, etc. will not be completed at this time****

****** All information is kept confidential and is used only for health-related purposes******

By Signing below I consent that, I have read and understand the information above and have provided to the best of my knowledge correct up to date information.

Signature: ____ Date: ___________________________________