**Intake Form**

We collect this information to help us communicate respectfully with you and provide you with the best possible care. We protect your information by following professional and privacy rules and laws. If you have any questions please contact [X].

**Your Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Legal Name\* (Last, First) | | Name Used | |
|  | |  | |
| Pronouns | Gender\* | | Birthdate (yyyy/mm/dd) |
|  |  | |  |
| Primary Phone | | Email | |
|  | |  | |

*\* Legal name and gender as stated on your BC Services Card. This information is collected to access your health records. We recognize that a person’s name and gender can differ from what is on their government issued ID.*

**Your Health Care Team**

Include any healthcare professional involved in your circle of care such as family doctor, nurse, cardiologist, rheumatologist, pain specialist, physiotherapist, dietician, social worker, etc.

|  |  |  |
| --- | --- | --- |
| Name | Role | Phone |
|  |  |  |
|  |  |  |
|  |  |  |

Include the community pharmacy where you fill most of your medications:

|  |  |  |
| --- | --- | --- |
| Pharmacy Name | Address | Phone |
|  |  |  |

**Your Health Details**

Rate your overall health. *Please select from 1 = worse imaginable, 10 = best imaginable*

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

**Describe your health concerns.** What do youwant to speak to the pharmacist about? Please be as specific as possible:

|  |
| --- |
|  |

**What are your goals for your visit?**

|  |
| --- |
|  |

**List your current medical conditions**:

|  |
| --- |
|  |

**List or include a copy of your current medications** (prescription and non-prescription such as natural health products and vitamins):

|  |
| --- |
|  |

If you have any documents for the pharmacists to review, please include them with this form.

**Other Information**

**How did you hear about us?**

|  |
| --- |
|  |