

INITIAL ASSESSMENT

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File number:

Last name, first name:

Date of birth:

Health insurance number:

GENERAL INFORMATION

Living environment: Living alone: Yes No Who lives with them?

Job and/or occupation:

Primary language:

Other language(s):

Registered for a telephone consultation service:

Registered on the waiting list to find a family physician:

Yes No

Yes No

Monitored by a community health centre (CLSC):

Local service network:

Yes No

What was your sex at birth?

What is your gender?

Male

Male

Female

Female

Non-binary

Other (specify):

Person's main concerns:

Person's objectives:

- 1.
- 2.
- 3.

Accompanied during the meeting by:

Family physician:

Medical, professional, and community resources in the medical or digital clinical record

Function/Position	Name	Phone #	Fax #	Setting

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Significant person(s):

Phone:

MEDICAL HISTORY (including history of ER visits and hospitalizations)

Allergies or comorbidities or risk factors: Indicated in the medical or digital clinical record

Or (specify):

CONNECT-6 score: / (Positive if the person gives two or more positive [yes] answers)

PORTRAIT-10 score: / (If any questions omitted, add to total score using the rule of 3) /40 (The higher the score, the more complex the person's needs)

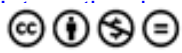
HEALTH STATUS

Physical health
(PORTRAIT-10, Questions 1, 2, and 3)

Psychological health
(PORTRAIT-10, Questions 4 and 5)

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Social situation (PORTRAIT-10, Questions 6, 7, and 8)	
Interactions with the healthcare system (PORTRAIT-10, Question 10)	
Evolution of the situation (PORTRAIT-10, Question 9)	
LIFESTYLE	
Nutrition <input type="checkbox"/> Available in medical or digital clinical record:	
Alcohol/drugs (PORTRAIT-10, Question 5) <input type="checkbox"/> Available in medical or digital clinical record:	
Tobacco <input type="checkbox"/> Available in medical or digital clinical record:	Factors influencing cessation (beliefs, knowledge, ability, support):

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Physical activity <input type="checkbox"/> Available in medical or digital clinical record:	Factors influencing regular physical activity (beliefs, knowledge, ability, support):
Other self-management behaviours	
Summary of the meeting (problems identified, person's priorities...)	
<input type="checkbox"/> Planning an individualized service plan (ISP) <input type="checkbox"/> Planning an interdisciplinary intervention plan (IIP) <input type="checkbox"/> Other:	
Data collected by:	Date:
Data completed by:	Date: