

Community Program Intake Form

Name: _____ **Today's Date:** _____
Last First mm dd yyyy

Preferred Name: _____
Last First

Ontario Health Card # _____ **Version:** _____

Federal Interim Health # _____ **Expires:** _____ **Date of Birth:** _____
(if applicable) mm dd yyyy

Address: _____ ☐ **No Fixed Address**

City: _____ **Province:** _____ **Postal Code:** _____

☐ **No Phone** **Home Phone:** (____) ____-____ **Other Phone:** (____) ____-____

Email: _____

Would you like to receive our newsletter or health bulletins? ☐ Yes ☐ No

Emergency Contact (include name and phone #): _____

LANGUAGE(S) SPOKEN/WRITTEN AT HOME:

☐ English ☐ French ☐ Spanish ☐ Italian
☐ Portuguese ☐ Punjabi ☐ Other _____

Do you require a translator? ☐ Yes ☐ No **Language:** _____

Name of Translator: _____ **Phone Number:** (____) ____-____

GENDER:

☐ Female ☐ Intersex ☐ Male ☐ Other _____
☐ Transgender ☐ Transgender ☐ Do not know ☐ Prefer not to answer
(Female to Male) (Male to Female)

RACIAL OR ETHNIC GROUP:

☐ Asian (East) ☐ Asian (South) ☐ Asian (South East) ☐ Black (African)
☐ Black (Caribbean) ☐ Black (North American) ☐ First Nations ☐ Indian-Caribbean
☐ Indigenous / Aboriginal ☐ Inuit ☐ Latin American ☐ Metis
☐ Middle Eastern ☐ White (European) ☐ White (North American) ☐ Mixed Heritage
☐ Other ☐ Prefer not to answer ☐ Do not know

Country of Origin: _____ **Canadian Citizen:** ☐ Yes ☐ No
Date of Arrival to Canada: _____ ☐ Landed Immigrant ☐ Refugee

ANNUAL HOUSEHOLD INCOME:

☐ \$0 - \$14,999 ☐ \$15,000 - \$19,000 ☐ \$20,000 - \$24,999 ☐ \$25,000 - \$29,999
☐ \$30,000 - \$34,999 ☐ \$35,000 - \$39,999 ☐ \$40,000 - \$59,999 ☐ \$60,000 or greater
☐ Do not know ☐ Prefer not to answer

SOURCE OF INCOME:

- ☐ Employment
 ☐ CPP
 ☐ ODSP
 ☐ Ontario Works (OW)
- ☐ Pension
 ☐ Other _____

CURRENT HOUSEHOLD COMPOSITION:

- ☐ Mother/Father/Child(ren)
 ☐ Couple without child
 ☐ Sole Member
 ☐ Grandparent(s) with grandchild(ren)
- ☐ Extended Family
 ☐ Unrelated Housemates
 ☐ Siblings
 ☐ Single parent family (Mother)
- ☐ Single parent family (Father)
 ☐ Same sex couple
 ☐ Do not know
 ☐ Prefer not to answer
- ☐ Other _____

HOMELESS STATUS:

- ☐ Not Homeless
 ☐ Homeless – No Address
 ☐ Shelter
 ☐ Other Temporary

LIVING ARRANGEMENTS:

- ☐ Private Home
 ☐ Senior Citizen home
 ☐ Apartment
 ☐ Son/Daughter's home
- ☐ Parent's home
 ☐ Other _____

HIGHEST EDUCATION LEVEL COMPLETED:

- ☐ Primary or equivalent (grades 1-8)
 ☐ Secondary or equivalent (grades 9-12)
- ☐ Post-secondary or equivalent
 ☐ Too young for primary completion
- ☐ No Formal Education
 ☐ Other _____
- ☐ Do not know
 ☐ Prefer not to answer

WELLBEING:

1. In general, would you say your overall **mental** health is:

- ☐ Excellent
 ☐ Very good
 ☐ Good
 ☐ Fair
 ☐ Poor

2. In general, would you say your overall **physical** health is:

- ☐ Excellent
 ☐ Very good
 ☐ Good
 ☐ Fair
 ☐ Poor

3. How would you describe your sense of belonging to your community? Sense of belonging is feeling like you are part of something, connected and accepted. Would you say your sense of belonging is:

- ☐ Very strong
 ☐ Somewhat strong
 ☐ Somewhat weak
 ☐ Very weak

PROTECTED AND CONFIDENTIAL WHEN COMPLETED

Thank you for completing this form which provides the Health Centre with statistics that are required by the Ministry of Health and Long-term Care. Bridges Community Health Centre (CHC) is a "Health Information Custodian" (as per The Personal Health Information Protection Act) which means that we store your Personal Health Information (PHI) in our systems. In accordance with the Act, we collect PHI directly from you or from the person acting officially on your behalf (e.g. your Substitute Decision Maker). The PHI that we collect may include your name, date of birth, Health Card Number, address, health history, records of your visits to Bridges CHC and the care that you received during those visits. Occasionally, we collect PHI about you from other sources only if we have obtained your consent or if permitted by law. Such other sources could include other health service providers working with us to provide care to you (e.g. hospitals, specialists, etc.). Staff at the Centre operate as a team to provide the best services possible to you. As such, you may deal with more than one staff member, which means that staff may need to share information to help serve you.

ALL INFORMATION IS KEPT CONFIDENTIAL WITHIN THE CENTRE AND IS USED ONLY FOR HEALTH-RELATED PURPOSES.

Comments or Limitations to Consent:

Date of Application: _____

☐ I have read and understand this information

☐ I have read and DO NOT understand but I consent to be registered in the computer.

Client Signature: (Please sign here →)