Bridges Community Health Centre
Fort Erie and Port Colborne/Wainfleet

Community Program Intake Form

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

Preferred Name: _____ (Last) _____ (First)

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

Federal Interim Health # (if applicable) _____ **Expires:** _____ **Date of Birth:** _____ (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 (Female to Male) ☐ Transgender (Male to Female) ☐ Do not know ☐ Prefer not to answer

SEXUAL ORIENTATION:

☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian
☐ Queer ☐ Two-Spirit ☐ Do not know ☐ Other _____
☐ Prefer not to answer

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

DISABILITIES:

- ☐ Chronic Illness
- ☐ Developmental disability
- ☐ Drug/Alcohol Dependence
- ☐ Learning Disability
- ☐ Mental Illness
- ☐ Physical Disability
- ☐ Sensory Disability
- ☐ None
- ☐ Other _____
- ☐ Do not know
- ☐ Prefer not to answer

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
- ☐ OW
- ☐ Pension
- ☐ Other _____

NUMBER OF PEOPLE SUPPORTED BY THIS INCOME:

- ☐ Enter number (1-20): _____
- ☐ Do not know
- ☐ Prefer not to answer

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. 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

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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:_____	☐ 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 →)** _____

IF YOU WILL BE RECEIVING CARE FROM THE DIABETES EDUCATION PROGRAM OR PHYSIOTHERAPY PROGRAM, PLEASE COMPLETED ADDITION REGISTRATION INFORMATION SPECIFIC TO EACH OF THOSE PROGRAMS

DIABETES EDUCATION PROGRAM

HEALTH and DIABETES:

Are you enrolled with a Family Physician or Nurse Practitioner? ☐ Yes ☐ No

If YES, who? _____ Last appointment _____ In what City/town? _____

If NO, who was your last Family Physician? In what City/town?

What Pharmacy do you use? _____

Do you give us consent to access your medication list and lab work? ☐ Yes ☐ No

What type of diabetes do you have? ☐ Pre-diabetes ☐ Type 2 Diabetes ☐ Type 1 Diabetes

When were you diagnosed with diabetes? _____

How do you manage your diabetes? ☐ diet/exercise ☐ medication ☐ insulin ☐ other

Date of last eye exam: _____

Have you had a foot exam?: ☐ Yes ☐ No

Please check any concerns you are having at this time with managing your diabetes:

- ☐ Financial pressures
- ☐ High blood sugars
- ☐ Low blood sugars
- ☐ Meal planning
- ☐ Dental problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Constipation or Diarrhea
- ☐ Vision problems
- ☐ Leg and foot pain
- ☐ Cigarette use
- ☐ Alcohol use

Please check any of the following topics that you are interested in learning about:

- ☐ Meal planning
- ☐ Reading nutrition labels
- ☐ Heart healthy eating
- ☐ Weight management
- ☐ Activity
- ☐ Medic alert bracelet
- ☐ Foot Care
- ☐ Using your glucometer
- ☐ Monitoring your blood sugars
- ☐ Medication management