Bridges Community Health Centre
Fort Erie and Port Colborne/Wainfleet

Diabetes Intake Form

Today's Date: _____
mm-dd-yyyy

Name: _____ (Last) _____ (First) **Date of Birth:** _____ (mm dd yyyy)

Preferred Name: _____ (Last) _____ (First)

Ontario Health Card #___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Expires:** _____ (mm dd yyyy)

Federal Interim Health # _____
(if applicable)

Address: _____ ☐ **No Fixed Address**

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

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

Email: _____ Would you like to receive emails from Bridges CHC? ☐ Yes ☐ No

Emergency Contact (include name and phone #): _____

LANGUAGE:

What is your Mother Tongue? (the language you first learned at home)

☐ English ☐ French ☐ Other (please specify): _____

If your mother tongue is neither French nor English, in which of Canada's official languages are you more comfortable?

☐ English ☐ French

In what language do you feel most comfortable speaking with your provider? (Check all that apply)

☐ English	☐ Greek	☐ Italian	☐ Romanian	☐ Tagalog
☐ French	☐ Cantonese	☐ Karen	☐ Russian	☐ Tamil
☐ Albanian	☐ Czech	☐ Korean	☐ Serbian	☐ Thai
☐ Amharic	☐ Dari	☐ Mandarin	☐ Slovak	☐ Tibetan
☐ Arabic	☐ Farsi	☐ Nepali	☐ Somali	☐ Tigrinya
☐ ASL (American Sign Language)	☐ Gujarati	☐ Pashto	☐ Spanish	☐ Taishanese/Toishanese
☐ Bengali	☐ Hausa	☐ Polish	☐ Swahili	☐ Urdu
☐ Bulgarian	☐ Hebrew	☐ Portuguese	☐ Turkish	☐ Vietnamese
☐ Burmese	☐ Hindi	☐ Punjabi	☐ Twi	☐ Do not know
☐ Georgian	☐ Hungarian	☐ Rohingya	☐ Ukrainian	☐ Prefer not to answer

☐ Another Language (please specify): _____

Do you require a translator? ☐ Yes ☐ No Language: _____
Name of Translator:_____ Phone Number:(____) _____-_____

IDENTITY:

Were you born in Canada?

☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

If NO, what year did you arrive in Canada? _____ In what country were you born? : _____

Do you identify as First Nations, Métis and/or Inuk/Inuit? (Check **ALL** that apply)
This question is about how you identify yourself (e.g. includes status or non-status)

☐ Yes, First Nations ☐ Yes, Inuk/Inuit ☐ Yes, Métis
☐ No ☐ Do not know ☐ Prefer not to answer

What is your ethnic or cultural background? For example: Canadian, Chinese, East Indian, English, Filipino, French, German, Irish, Italian, Jamaican, Jewish, Polish, Portuguese, Scottish, etc.

_____

Which of the following best describes your racial group?
(Check **ALL** that apply, for example if you are multi-racial or mixed race)

☐ White (e.g., European descent)
☐ Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.)
☐ Latin American (Hispanic or Latin American descent)
☐ East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.)
☐ South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.)
☐ Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.)
☐ Middle Eastern, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.)
☐ Another race/ethnic group (Please specify): _____

☐ Do not know ☐ Prefer not to answer ☐ Not Applicable (e.g., Identified as Indigenous)

Gender/Orientation:

What is your sex assigned at birth? (Select only **ONE**)

☐ Female ☐ Male ☐ Intersex ☐ Do not know ☐ Prefer not to answer

What is your current gender identity? (Check **ALL** that apply)

☐ Woman ☐ Genderfluid or genderqueer ☐ Two-Spirit ☐ Do not know
☐ Man ☐ Questioning or unsure ☐ Nonbinary ☐ Prefer not to answer
☐ Another gender identity (Please specify): _____

Do you identify as transgender?
Transgender is an umbrella term used to describe people whose gender identity or gender expression differs from the sex they were assigned at birth.

☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

Which category (ies) best describe your sexual orientation? (Check **ALL** that apply)

- ☐ Asexual
- ☐ Bisexual
- ☐ Demisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Questioning or unsure
- ☐ Same-gender loving
- ☐ Two-spirit
- ☐ Straight/Heterosexual (male/female relationships)
- ☐ Do not know
- ☐ Prefer not to answer
- ☐ Another sexual orientation (please specify): _____

EDUCATION/ INCOME:

What is your current level of education?

- ☐ No formal schooling
- ☐ Some high school, but did not graduate
- ☐ Completed Registered Apprenticeship or other trades certificate or diploma (or ongoing)
- ☐ College, CEGEP or other non-university certificate or diploma (or ongoing)
- ☐ Undergraduate degree or some university
- ☐ Postgraduate degree or professional designation (e.g., Master's, PhD, MD)
- ☐ Do not know
- ☐ Grade school (grade 1-8)
- ☐ High school or high school equivalency certificate (grade 9-12)
- ☐ Prefer not to answer

What was your total family income before taxes last year?

Yearly income before tax	Per month	Per hour
☐ $0 - $19,999	$0 – 1667	$0 - $10.26/hr
☐ $20,000 – $39,999	$1,668 – 3,333	$10.26 - $20.51/hr
☐ $40,000 - $59,999	$3,334 – 4,999	$20.51 - $30.77/hr
☐ $60,000 - $79,999	$5,000 – 6,667	$30.77 - $38.46/hr
☐ $80,000 - $119,999	$6,667 – 9,999	$38.46 - $61.54/hr
☐ $120,000 - $149,999	$10,000 – 12,499	$61.54 - $76.92/hr
☐ $150,000 or more	$12,500 or more	$76.92 and up/hr
☐ Do not know	☐ Prefer not to answer	

How many people does this income support? *Include yourself + any dependents such as parents, children, etc.*

_____ Number of person(s)

WELLBEING:

Do you identify as a person with a disability?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer
- ☐ If you wish, please specify: _____

Could you benefit from support related to any of the following? (Check **ALL** that apply)

- ☐ Sensory Disability (e.g., low vision, blindness, deafness, hard of hearing etc.)
- ☐ Alzheimer's Disease/Dementia
- ☐ Autism Spectrum Disorder
- ☐ Chronic Illness (e.g. sickle cell, diabetes etc.)
- ☐ Other (Please specify): _____
- ☐ Developmental Disability
- ☐ Drug or Alcohol Dependence
- ☐ Learning Disability
- ☐ Prefer not to answer
- ☐ Cognitive Disability
- ☐ Physical Disability
- ☐ Mental Illness
- ☐ None
- ☐ Do not know

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

- ☐ Very Weak
- ☐ Somewhat Weak
- ☐ Somewhat Strong
- ☐ Very Strong
- ☐ Do not know
- ☐ Prefer not to answer

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

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ Do not know ☐ Prefer not to answer

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

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ Do not know ☐ Prefer not to answer

Housing

What is your current housing situation?

- ☐ A place you or your family owns
- ☐ A place you or your family rents
- ☐ Correctional facility
- ☐ Long -term care facility
- ☐ Do not know
- ☐ Other (Please specify): _____
- ☐ Staying in someone else's place because you have no alternative
- ☐ Experiencing homelessness (e.g., shelter, living in a public place or vehicle)
- ☐ Social housing, Subsidized housing or Rent -geared -to –income
- ☐ Supportive housing or Group Home
- ☐ Prefer not to answer

Who do you live with? (Check **ALL** that apply)

- ☐ Parent(s) or Guardian(s)
- ☐ Spouse or Partner
- ☐ Child(ren)
- ☐ Grandparent(s)
- ☐ Sibling(s)
- ☐ Other family
- ☐ Friends or Roommates
- ☐ Paid caregiver or attendant
- ☐ Alone
- ☐ Do not know
- ☐ Prefer not to answer
- ☐ Other (Please specify): _____

Basic Needs

Do you currently have difficulty paying for basic needs?

☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

☐ Not applicable, I do not have to pay for basic needs

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