Bridges Community Health Centre
Fort Erie and Port Colborne/Wainfleet

Physiotherapy 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
- ☐ Grade school (grade 1-8)
- ☐ High school or high school equivalency certificate (grade 9-12)
- ☐ 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
- ☐ 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

PHYSIOTHERAPY PROGRAM

HEALTH INSURANCE or PERSONAL HEALTH COVERAGE:

Do you have personal health coverage? ☐ Yes ☐ No If yes, are physiotherapy services covered? ☐ Yes ☐ No

Name of Health Insurer or Benefit Company: _____

Amount allowed for physiotherapy/year: $_____ Have you used all physio benefits this year? ☐ Yes ☐ No

HEALTH PROVIDER HISTORY:

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

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

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

REASON FOR PHYSIOTHERAPY:

What body area is affected? _____

When did the problem/discomfort begin? _____

What activity caused the discomfort to begin? _____

ADDITIONAL MEDICAL INFORMATION:

What medication are you currently taking? _____

Do you have any allergies? _____

Other: _____

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 below)**