

DISABILITIES:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Drug/Alcohol Dependence | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Sensory Disability | <input type="checkbox"/> None |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |

ANNUAL HOUSEHOLD INCOME:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> \$0 - \$14,999 | <input type="checkbox"/> \$15,000 - \$19,000 | <input type="checkbox"/> \$20,000 - \$24,999 | <input type="checkbox"/> \$25,000 - \$29,999 |
| <input type="checkbox"/> \$30,000 - \$34,999 | <input type="checkbox"/> \$35,000 - \$39,999 | <input type="checkbox"/> \$40,000 - \$59,999 | <input type="checkbox"/> \$60,000 or greater |
| <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer | | |

SOURCE OF INCOME:

- | | | | |
|-------------------------------------|--------------------------------------|-------------------------------|-----------------------------|
| <input type="checkbox"/> Employment | <input type="checkbox"/> CPP | <input type="checkbox"/> ODSP | <input type="checkbox"/> OW |
| <input type="checkbox"/> Pension | <input type="checkbox"/> Other _____ | | |

NUMBER OF PEOPLE SUPPORTED BY THIS INCOME:

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Enter number (1-20): _____ | <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |
|---|--------------------------------------|---|

CURRENT HOUSEHOLD COMPOSITION:

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

HOMELESS STATUS:

- | | | | |
|---------------------------------------|---|----------------------------------|--|
| <input type="checkbox"/> Not Homeless | <input type="checkbox"/> Homeless- No Address | <input type="checkbox"/> Shelter | <input type="checkbox"/> Other Temporary |
|---------------------------------------|---|----------------------------------|--|

LIVING ARRANGEMENTS:

- | | | | |
|--|--|------------------------------------|--|
| <input type="checkbox"/> Private Home | <input type="checkbox"/> Senior Citizen home | <input type="checkbox"/> Apartment | <input type="checkbox"/> Son/Daughter's home |
| <input type="checkbox"/> Parent's home | <input type="checkbox"/> Other _____ | | |

HIGHEST EDUCATION LEVEL COMPLETED:

- | | |
|---|--|
| <input type="checkbox"/> Primary or equivalent (grades 1-8) | <input type="checkbox"/> Secondary or equivalent (grades 9-12) |
| <input type="checkbox"/> Post-secondary or equivalent | <input type="checkbox"/> Too young for primary completion |
| <input type="checkbox"/> No Formal Education | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |

Fort Erie site:

1485 Garrison Rd, Fort Erie ON, L2A 1P8

Phone: 905-871-7621

Fax: 905-871-9135

Port Colborne site:

380 Elm Street, Rear, Port Colborne ON, L3K 4G5

Phone: 289-479-5017

Fax: 905-835-7756

WELLBEING

- 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
- In general, would you say your overall **physical** health is:
 Excellent Very good Good Fair Poor
- 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: _____	<input type="checkbox"/> I have read and understand this information <input type="checkbox"/> I have read and DO NOT understand but I consent to be registered in the computer. Client Signature: (Please sign here →) _____
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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