Bridges Community Health Centre
Fort Erie and Port Colborne/Wainfleet

Physiotherapy Group 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 #): _____

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

If YES, who? _____

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

Client Activity Agreement Release and Waiver Form

(If you are under 18 years of age, a parent/guardian signature is required)
Attention: Please read the following very carefully as it affects your legal rights.

I, by signing below, and in participating in physical activities and programs offered to me through Bridges Community Health Centre (CHC), fully understand and agree to the following:

1. I acknowledge that the activities and programs that I choose to participate in with Bridges CHC may involve certain elements of personal risk or the chance of an accident or injury, and I hereby release Bridges CHC and its elected directors, employees and agents and their respective successors, assigns, heirs and executors from all claims for loss, damage or injury.

2. I will abide by all applicable Bridges CHC policies and rules, as may be amended from time to time, and will follow all instructions of the appropriate Bridges CHC staff in carrying out the activities and programs in which I choose to participate.

3. I will not over exert myself and will only carry out the activities that I know I can do safely and properly, as per my physician's recommendations.

4. I will immediately notify the appropriate Bridges CHC staff of any incident that involves property damage or personal injury during my activity.

By signing this form:

- **I acknowledge that I have read and understood the preceding conditions, release and waiver; and**
- **I agree to the preceding conditions, release and waiver.**

If the client is under the age of 18, by signing this form as a parent or guardian:

- **I acknowledge that I have read and understood the preceding conditions, release and waiver; and**
- **I agree to the preceding conditions, release and waiver as they apply to my child;**
- **I have given permission for my child to participate in the activity specified above with Bridges CHC**

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 **Client Signature: (Please sign below →)**