Centre de santé communautaire
CHIGAMIK
Community Health Centre
La place du people – The Peoples' Place
845 King St, Unit 10, Midland ON L4R 0B7 ph.: 705.527.4681 fax: 705.526.2870

Every One Matters.
Chaque personne compte.

Client #_____________

CLINICAL INTAKE FORM

Name: ___________________________________ **Date of birth:** ________________________(dd-mm-yyyy)

Preferred Name (if different from above): _________________________________ **Middle initial**:_____________

Address:_________________________________ **City**: __________________ **Postal Code:** __________________

◯ No permanent address

Email Address: ______________________________

Health Card Number: Province: ____ Number: __ __ __ __ __ __ __ __ __ __ Version Code: __ __

Expiry Date: _________________(dd-mm-yyyy)

Phone Number: 1)cell_____________________ 2) home___________________3) work____________________

Emergency Contact: Name_____________________ Phone__________________Relationship________________

Do you wish to self-identify as one or more of the following?

◯ **Francophone** ◯ **First Nations** ◯ **Métis** ◯ **Inuit**

EXTENDED DEMOGRAPHICS

Insurance:

Do you have Supplemental Insurance? ◯ No ◯ Yes: ◯ Prefer not to answer

◯ Interim Federal Health Card ◯ Aboriginal Non-Insured Health Benefits

◯ Third Party Private Insurer: ____

Do you have a Drug Plan? ◯ No ◯ Yes: ◯ Prefer not to answer

◯ Ontario Disability Support Program ◯ Ontario Works ◯ Ontario Drug Benefits

◯ Trillium Drug Program ◯ Cancer Care ◯ Special Drugs Program ◯ Inherited Metabolic Diseases

◯ Other: _______________________________________

Gender Identity:

◯ Male ◯ Female ◯ Transgender Male to Female ◯ Transgender Female to Male ◯ Prefer not to answer

◯ Intersex ◯ Do not know ◯ Two-spirit ◯ Other: __________

Sexual Orientation:

◯ Heterosexual ("straight") ◯ Lesbian ◯ Bisexual ◯ Do not know ◯ Prefer not to answer

◯ Queer ◯ Gay ◯ Two-spirit ◯ Other:___________

Highest level of education:

◯ Too young for Primary school ◯ College ◯ No formal education

◯ Primary School, Grade 1-8 ◯ University Bachelor's ◯ Do not know

◯ Secondary School, Grade 9-12 ◯ University Post-Graduate ◯ Other:________________

◯ Prefer not to answer

Combined annual household income:

◯ $0 - 14,999
◯ $15,000 - 19,999
◯ $20,000 - 24,999
◯ $25,000 - 29,999
◯ $30,000 - 34,999
◯ $35,000 - 39,999
◯ $40,000 - 59,999
◯ $60,000 - 89,999
◯ $90,000 - 119,999
◯ $120,000 - 149,999
◯ $150,000 or more
◯ Do not know
◯ Prefer not to answer

How many people are supported on this income (including children and dependants): ___________________

Describe your household composition:

◯ Parents / guardians with children
◯ Couple with no children
◯ Sole member
◯ Do not know
◯ Extended family
◯ Siblings
◯ Grandparents with child(ren)
◯ Other:____________________
◯ Single parent
◯ Unrelated housemates
◯ Prefer not to answer

Homeless Status: ◯ Not homeless ◯ Homeless, no address ◯ Shelter ◯ Other, temporary
◯ Prefer not to answer

Language: ◯ Prefer not to answer

Which of Canada's official languages would you like to be served in? ◯ English ◯ French

What is your Mother tongue/Language of Origin? ◯ English ◯ French ◯ Other: ___________________

Is an interpreter required for appointments? ◯ Yes ◯ No

Background:
Please check what best describes your racial or ethnic group:

◯ White, European
◯ White, North American
◯ Middle Eastern
◯ Asian, East
◯ Asian, South
◯ Asian, Southeast
◯ First Nations
◯ Métis
◯ Inuit
◯ Latin American
◯ Indian, Caribbean
◯ Mixed:
◯ Black, African
◯ Black, Caribbean
◯ Black, African American
◯ Indigenous/Aboriginal
◯ Do not know
◯ Other:________________________
◯ Prefer not to answer

Country of Origin: ◯ Canada ◯ Other: __________________ ◯ Prefer not to answer
Date/year of arrival in Canada: ________________

Do you follow a religion/belief system? ◯ Yes:__________________ ◯ No ◯ Prefer not to answer

Disability:
Do you have any of the following disabilities?

◯ Chronic Illness
◯ Developmental
◯ Learning
◯ Mental Illness
◯ Physical
◯ Sensory
◯ Drug or alcohol dependence
◯ Do not know
◯ None
◯ Other:________________________
◯ Prefer not to answer

Wellbeing:

How would you rate your sense of belonging in your community today? This means having a group of people you connect with who respects you, shared activities and experiences, emotional bonds with others, having people to care about and who care about you. ◯ Prefer not to answer

◯ Very Weak ◯ Somewhat Weak ◯ Somewhat Strong ◯ Very Strong

How would you rate your physical health and well-being today? Choose one ◯ Prefer not to answer

◯ Poor ◯ Fair ◯ Good ◯ Very Good ◯ Excellent

How would you rate your mental health and well-being today? Choose one ◯ Prefer not to answer

◯ Poor ◯ Fair ◯ Good ◯ Very Good ◯ Excellent

Are you taking any medications? If yes, what do you take them for?

Medication	Reason

Do you have any allergies? If yes, how do you react?

Allergies	Reaction

Which Pharmacy do you use? ____

Permission to contact pharmacy for medication profile □ No □ Yes

Service Agreement: Program and Services Consent Form

CSC CHIGAMIK CHC is responsible for keeping the privacy and confidentiality of all the information we collect about clients. All personnel (staff, students, and volunteers) at CSC CHIGAMIK CHC are held accountable to organizational policies regarding confidentiality, privacy, consent, and release of information as well as the Personal Health Information and Privacy Act, and the standards of their professional college.

I understand that CSC CHIGAMIK CHC operates as a team to provide the best health care possible. In order to do this, my health care information may be shared between appropriate team members for collaboration (within the Centre) and/or to specialists for referrals (outside the Centre). All clinical and allied health providers, including physiotherapists, social workers, dietitians, nurse practitioners, physicians, and nurses, keep their notes in the same client file.

1. CHIGAMIK will only collect pertinent information necessary to provide appropriate services to clients and/ or the community and to meet the legal/ funding requirements. I understand that, when necessary, my health care information may be shared with:
   - CSC CHIGAMIK CHC Primary Health Care Services (Nurse Practitioners, Physicians, Nurses and Medical/Nursing Administrative Personnel).
   - CSC CHIGAMIK CHC allied health professionals (Physiotherapist, Dietitian and Mental Health/Addictions Therapists).
   - Professionals outside CSC CHIGAMIK CHC to whom I have agreed to be referred.
2. A health care record is created for each client receiving care at CSC CHIGAMIK CHC. All of the information collected from clients is stored electronically on the Centre's electronic medical record software. The client's personal health information is password protected, with access restricted to staff on the health care team.
3. All clients registered at CSC CHIGAMIK CHC are asked to provide demographic information required by the CHC Evaluation Framework. This information allows us to provide you with services and programs that meet your needs. Demographic information may also be used to support research reports and funding proposals, however, in these cases, this information will not be linked to your name or other identifying information.
4. Clients are informed of the reasons for the collection, use and disclosure of their personal health information and their express consent will be obtained.
5. Personal information will not be used or disclosed for purposes other than those for which it was collected, except with the client's consent or as required by law. Personal information will only be kept as long as necessary to complete the above (1&2) and then disposed of in a secure manner.
6. Clients have the right to access or obtain a copy of their information, request a correction of information, have assistance in interpreting their record, and/or withdraw or withhold consent
7. Assistance in understanding the record will be the responsibility of the primary care provider. If the provider is concerned that releasing the information could be harmful to the client; the team will be consulted prior to the release. Staff will respond to a request to view personal health information within 30 days.

Restrictions

I understand that no part of my medical record will be released to anyone outside CSC CHIGAMIK CHC without my specific written consent, except when the law requires. Examples of this include:

- The law requires us to report to child welfare authorities when there is suspicion or disclosure of abuse or neglect of a child under the age of 16.
- If we have reason to believe a client will seriously harm him/ herself or another, a report will be made to authorities in order to ensure safety of all.
- Records will be shared if we are required to do so by a court of law (subpoena).

I have had the above information explained to me, I understand, and I consent to the above for the duration of my health care at CSC CHIGAMIK CHC.

Client Signature: ____ Date (dd-mm-yyyy): ____________________