Centre de santé communautaire
CHIGAMIK
Community Health Centre

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** ◯ **Indigenous** ◯ **Métis** ◯ **Inuit** ◯ **Francophone and Indigenous** ◯ **None**

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 <u>community</u> 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 <u>physical</u> health and well-being today? Choose one ◯ Prefer not to answer

◯ Poor ◯ Fair ◯ Good ◯ Very Good ◯ Excellent

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

◯ Poor ◯ Fair ◯ Good ◯ Very Good ◯ Excellent

Are you currently a rostered patient of any other Primary Care Provider (Doctor or Nurse Practitioner)?: □ No □ Yes

Please provide the name of your current or most recent Primary Care Provider and the approximate date of your last appointment: _____

Please provide details regarding your medical history including any past surgeries and/or hospitalizations:

Medical Conditions and Diagnosis (include approximate date of diagnosis)	**Past Surgeries and/or Hospitalizations (include approximate dates)**

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 or Pharmacies do you use? _____

Permission to contact pharmacy for medication profile □ No □ Yes

Client Rights and Responsibilities

Every client has the right:

1. To be treated with respect by all staff, volunteers and students in a way that fully recognizes the client's dignity and individuality.
2. To be assured that personal information is kept confidential by Centre staff, students, and volunteers. Volunteers will not have access to clients' medical files. Disclosure of information outside of the clinic will only happen with the client's written permission, in the case of a life-threatening crisis, or if ordered by a court of law. In rare instances, courts may subpoena medical files. In addition, staff is required by law to report the following circumstances: cases of client in imminent danger of harming themselves or others; any reasonable suspicions of neglect and /or emotional, physical, or sexual abuse of a minor; sexual relations with and or abuse of a healthcare professional; and certain communicable diseases.
3. To be told who is responsible or directing their care.
4. To be informed of their medical condition, test results and proposed course of treatment; to accept or refuse treatment, including medication, and to be informed of consequences of accepting or refusing treatment.
5. To be assured of privacy during personal interviews, counseling sessions and medical assessments.
6. To decline to see a student healthcare professional whether under the supervision of a healthcare professional or not.
7. To have access, through an assigned healthcare professional, to their health records on request, and to understand what they mean.
8. To designate a person to receive information regarding the clients' medical condition and treatment and, if necessary, to make decisions on the clients' behalf, in accordance with the law.
9. To raise any concerns they may have regarding the clients' health care or to recommend changes, without fear of retaliation. (For information on how to initiate a complaint, contact any member of our healthcare team or visit the Client Experience section of the Chigamik Website).
10. To receive care in a safe and clean environment.

Every client has the responsibility:

1. To abide by Chigamik's Zero Tolerance Policy towards any abuse or harassment of staff or volunteers, including any behaviour that is seen as intimidating, offensive, humiliating or threatening.
2. To provide relevant and accurate information to the members of the healthcare team.
3. To register with the CSC CHIGAMIK CHC if requesting access to primary care services.
4. To accept responsibility for the decisions they make about their treatment.
5. To tell the healthcare professional or counselor when information is needed or when the instructions are not understood.
6. To follow the treatment plan that the client's healthcare provider and/or counselor and the client have agreed upon. If a client is unable follow the treatment plan, they are expected to inform the healthcare professional.
7. To recognize that healthcare professionals do not provide any treatment that they consider to be medically or ethically inappropriate.
8. To recognize that the needs of other clients may sometimes be more urgent than one's own.
9. To respect Centre property and comply with Centre regulations and policies.
10. To be responsible for expenses not covered by OHIP or private insurance, unless otherwise negotiated. This shall be identified when consent is obtained for respective procedure.
11. To respect the time of staff and other clients and call the Centre with at least 24 hours notice when unable to keep an appointment.
12. To follow CSC CHIGAMIK CHC's philosophy by being respectful and courteous to staff, students and clients, no matter their race, gender, sexual orientation, disability, financial status, ancestry, record of offence or family status.
13. To inform the Centre if they have concerns with their treatment at the centre.
14. To refrain from taking pictures, videos and/or audio recording during your time at the centre, this includes during programs, appointments, and when in the waiting room or other public areas.

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): _____