

Date Completed: \_\_\_\_\_

**(update for all clients annually)**

Community Health Centres are non-profit and funded by the LHIN (Local Health Integration Network). We are required to collect this data which allows us to identify the communities we most serve. This information is used to increase access to services and improve the quality of care. **Your information will be kept confidential, in keeping with federal and provincial legislation.** This data will only be seen internally by your health team, and externally only combined with data from all, without identifiers (i.e. 30 clients who speak English). The boxed items are mandatory for us to be able to provide services. The other questions all have options of prefer not to answer or do not know, if you choose not to complete. If you have any questions, or if you need help to complete the form, please share them with your provider. Thank you.

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Sex:** Female  Male   
DD MMM YYYY

**Health Card #:** \_\_\_\_\_ **Version Code:** \_\_\_\_\_ **Expiry Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Or dd mm yy

**Interim Federal Health #:** \_\_\_\_\_ **Expiry Date:** \_\_\_\_\_

**This information must match 1) OHIP or Health Insurance information OR 2) legal identification i.e. Birth Certificate etc.**

I am not insured, but expect a health card by: \_\_\_\_\_  
(month)  I am not insured, and do not expect a health card.  
 I am not insured and homeless

**Alias/Preferred Name:** \_\_\_\_\_ If different from above (place in brackets beside first name in NOD)

**Home Address and Contact Information**

\_\_\_\_\_ **Apt or Unit #** \_\_\_\_\_ **Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Postal Code** \_\_\_\_\_

**OR check if:**  I live in a shelter  I am homeless  Other: \_\_\_\_\_

**Telephone:** \_\_\_\_\_  
**Primary telephone #** \_\_\_\_\_ **Secondary telephone #** \_\_\_\_\_ **Additional telephone #** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_  
**Name of emergency contact** \_\_\_\_\_ **Relationship to you** \_\_\_\_\_ **Contact's phone number #** \_\_\_\_\_

**If no emergency contact information given, must enter none given and detail in notes of contact section of EMR**

**Spoken Language** (what language are you most comfortable speaking in with your health care provider) Check ONE only

- Arabic  English  Italian  Polish  Tagalog  Vietnamese
- ASL  French  Korean  Portuguese  Tamil
- Bengali  German  Mandarin  Punjabi  Twi
- Cantonese  Greek  Mi'kmaq  Russian  Ukrainian
- Cree  Hindi  Ojibwe  Serbian  Urdu
- Dari  Inuktitut  Oji-Cree  Spanish
- Other (please specify) \_\_\_\_\_

**Which category best describes your racial group?**

Check ONE checkbox selection only, then detail/specify at bottom.

- Asian-East (i.e. Chinese, Japanese, Korean)
- Asian-South (i.e. Indian, Pakistani, Sri Lankan)
- Asian-South East (i.e. Malaysian, Filipino, Vietnamese)
- Black-African (i.e. Ghanaian, Kenyan, Somali)
- Black-Caribbean (i.e. Barbadian, Jamaican)
- Black-North American (i.e. Canadian, American)
- First Nations
- Indian-Caribbean (i.e. Guyanese with origins in India)
- Indigenous/Aboriginal – not included elsewhere
- Inuit
- Latin American (i.e. Argentinean, Chilean, Salvadoran)
- Metis
- Middle Eastern (i.e. Egyptian, Iranian, Lebanese)
- White-European (i.e. English, Italian, Portuguese, Russian)
- White-North American (i.e. Canadian, American)
- Mixed Heritage (i.e. Black-African & White-North American)
- Please Specify: \_\_\_\_\_
- Prefer not to answer
- Do not know
- Indicate Ethnicity: \_\_\_\_\_

**Were you born in Canada?**  Yes  No a) If **NO**, in what country were you born? \_\_\_\_\_

b) **Date of arrival in Canada?** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 DD MMM YYYY

Do Not Know  Prefer Not to Answer

**If unsure of exact date, use 01/01 dd/mm and correct year**

**Do you have any of the following?** Check **ALL** that apply.

- Chronic Illness  Developmental Disability  Drug or Alcohol Dependence  Learning Disability  
 Mental Illness  Physical Disability  Sensory Disability (i.e. hearing loss)  None  
 Do Not Know  Prefer Not To Answer  Other - Please Specify: \_\_\_\_\_

**Gender Identity** is your sense of self, specifically your sense of being male, female, both or neither. It may be different from your biological sex and includes the options below.

**What is your gender?** Check **ONE** only.

- Female  Trans-Female to Male  Other (Please Specify): \_\_\_\_\_  
 Intersex  Trans-Male to Female  Do Not Know  
 Male  Two-Spirit  Prefer Not To Answer

**Sexual Orientation** is who you are attracted to romantically. People define their sexual orientation in various ways.

**What is your sexual orientation?**

- Bisexual  Gay  Heterosexual ("straight")  Lesbian  Queer  Two-Spirit  
 Other (Please Specify): \_\_\_\_\_  Do Not Know  Prefer Not To Answer

**What was your total family income before taxes last year?** Check **ONE** only.

- \$0.00 - \$14,999 (\$1,249/month or less/no income)  \$30,000 - 34,999 (\$2,500 - 2,916/month)  
 \$15,000 - \$19,999 (\$1,249 - 1,667/month)  \$35,000 - 39,999 (\$2,916 - 3,333/month)  
 \$20,000 - 24,999 (\$1,667 - 2,083/month)  \$40,000 - \$59,999 (\$3,333 - 4,999/month)  
 \$25,000 - 29,999 (\$2,083 - 2,500/month)  over \$60,000 (over \$5,000 /month)  
 Do Not Know  Prefer Not To Answer

**How many people does this income support?** (including dependants, parents, child support etc.)

# of \_\_\_\_\_ person(s)  Prefer not to answer  Do not know

**What is your current living arrangement?** (place where you reside)

- Apartment  House  Rooming House  Shelter  Homeless  Other/Temporary: \_\_\_\_\_

**Who lives in your household?** Check **ONE** only.

- Couple with child(ren)  Extended family (other relatives)  Single parent – father w/child(ren)  
 Couple without child(ren)  Unrelated housemates (incl.friends)  Single parent – mother w/child(ren)  
 Same Sex Couple with child(ren)  Siblings (adults without parents)  Sole member/live alone  
 Same Sex Couple without child(ren)  Grandparents/grandchildren  Other(specify): \_\_\_\_\_  
 Do Not Know  Prefer Not To Answer

**What is your highest Completed level of education?** Check **ONE** only.

- Primary school (grade 1-8)  Post-secondary (college, university, trade school)  None  
 High school (grade 9-12)  Too young for school  Do Not Know  
 Prefer Not To Answer  Other (specify): \_\_\_\_\_