Client Registration Form

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

PLEASE PRINT CLEARLY – USE PEN

Name:

……..
Last name First name Initial

Date of Birth: ……/……/……
Day Month Year

Address: ……..☐ no fixed address
and Street Apt # City Postal Code

Home Phone: (……)……-…… **Cell Phone:** (……)……-……

Preferred Phone: (……)……-……

If we call the preferred number, may we leave a message? ☐ Yes ☐ No

E-mail: …….....
*Note: We do not disclose any medical results or personal information via e-mail.

☐ I consent to AJHS sending me electronic communications including newsletters about programs and services and centre wide updates.

Emergency Contact: ……..**Phone:** (……)……-……
*By providing this information you give AJHS permission to contact this individual in case of an emergency.

Emergency Contact's Relationship to You: ……

Doctor's Name: ……..**Phone:** (……)……-……

Pharmacy Name: ……..**Phone:** (……)……-……

Power of Attorney Name (if applicable): ……..**Phone:** (……)……-……

OHIP #: …….. **Version Code:** …… **Expiry Date:** ……../……../……
Day Month Year

Other Healthcare Coverage:

Provincial Insurance #: ……Expiry Date: ……../……../……..
Day Month Year

Interim Federal Coverage (IFC) #: ……Expiry Date: ……../……../……..
Day Month Year

Private or extended health insurance? ☐ No ☐ Yes

No health card:

Are you in a 3-month waiting period? ☐ No ☐ Yes ……/……/……
(Date you expect to receive your health card – dd/mm/yy)

Allergies: ☐ No ☐ Yes……

If you have any health concerns or allergies, please tell staff

Socio-Demographic Information

We are collecting social information from clients to find out who we serve and what unique needs our clients have. We will also use this information to understand client experiences and outcomes.

Do I have to answer all the questions? Yes. The questions are voluntary but if you prefer not to answer a question, we ask that you choose 'prefer not to answer'. This will not affect your care.

Who will see this information? This information will be visible only to your health-care team and protected like all your other health information. If used in research, this information will be combined with data from all other clients and no one will be able to identify any of the clients.

1. What language do you feel most comfortable speaking in with your health care provider? (Check **ONE** only)

- ☐ 1. Amharic
- ☐ 2. Arabic
- ☐ 3. ASL
- ☐ 4. Bengali
- ☐ 5. Chinese (Cantonese)
- ☐ 6. Chinese (Mandarin)
- ☐ 7. Czech
- ☐ 8. Dari
- ☐ 9. English
- ☐ 10. Farsi
- ☐ 11. French
- ☐ 12. Greek
- ☐ 13. Hindi
- ☐ 14. Hungarian
- ☐ 15. Italian
- ☐ 16. Karen
- ☐ 17. Korean
- ☐ 18. Nepali
- ☐ 19. Polish
- ☐ 20. Portuguese
- ☐ 21. Punjabi
- ☐ 22. Russian
- ☐ 23. Serbian
- ☐ 24. Slovak
- ☐ 25. Somali
- ☐ 26. Spanish
- ☐ 27. Tagalog
- ☐ 28. Tamil
- ☐ 29. Tigrinya
- ☐ 30. Turkish
- ☐ 31. Twi
- ☐ 32. Ukrainian
- ☐ 33. Urdu
- ☐ 34. Vietnamese
- ☐ 35. Other (Please specify): ……
- ☐ 98. Prefer not to answer
- ☐ 99. Do not know

2. Were you born in Canada? ☐1. Yes ☐2. No ☐98. Prefer not to answer ☐99. Do not know

If NO, when did you arrive in Canada? ……/……/……. **What country were you born in?** ……..…
Day Month Year

3. Which of the following best describes your racial or ethnic group? (Check **ONE** only).

- ☐1. Asian – East (eg. Chinese, Japanese, Korean)
- ☐2. Asian – South (eg. Indian, Pakistani, Sri Lankan)
- ☐3. Asian – South East (eg. Malaysian, Filipino, Vietnamese)
- ☐4. Black – African (eg. Ghanaian, Kenyan, Somali)
- ☐5. Black – Caribbean (eg. Barbadian, Jamaican)
- ☐6. Black – North American (eg. Canadian, American
- ☐7. First Nations
- ☐8. Indian – Caribbean (e.g. Guyanese with or origins in India
- ☐9. Indigenous/Aboriginal
- ☐10. Inuit
- ☐11. Latin American (eg. Argentinean, Chilean, Salvadoran)
- ☐12. Métis
- ☐13. Middle Eastern (eg. Egyptian, Iranian, Lebanese)
- ☐14. White – European (eg. English, Italian, American)
- ☐15. White – North American(eg. Canadian, American)
- ☐16. Mixed heritage (eg. Black – African and White North American) Please specify: ……
- ☐17. Other(s). Please specify: ……
- ☐98. Prefer not to answer
- ☐99. Do not know

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

- ☐ 1. Chronic illness
- ☐2. Developmental disability
- ☐3. Drug or alcohol dependence
- ☐4. Learning disability
- ☐5. Mental Illness
- ☐6. Physical disability
- ☐7. Sensory disability (i.e. hearing or vision loss)
- ☐8. Other (Please specify): **……**
- ☐9. None
- ☐98. Prefer not to answer
- ☐99. Do not know

5. What is your gender? (Check **ONE** only)

- ☐ 1. Female
- ☐ 2. Intersex
- ☐ 3. Male
- ☐4. Trans – Female to Male
- ☐5. Trans – Male to Female
- ☐6. Two-spirit
- ☐7. Other (Please specify): ……
- ☐98. Prefer not to answer
- ☐99. Do not know

6. What is your sexual orientation? (Check **ONE** only)

- ☐ 1. Bisexual
- ☐ 2. Gay
- ☐3. Heterosexual ("straight")
- ☐4. Lesbian
- ☐5. Queer
- ☐6. Two-spirit
- ☐7. Other (Please specify): ……
- ☐98. Prefer not to answer
- ☐99. Do not know

7. Highest Education Level Completed (Check **ONE** only**):**

- ☐1. No formal schooling
- ☐2. Primary (Grades 1-8)
- ☐3. Secondary (Grades 9-13)
- ☐4. Post-secondary (College/University)
- ☐5. Other (Please specify): ……..
- ☐98. Prefer not to answer
- ☐99. Do not know

8. Describe your household (Check **ONE** only):

☐1. Living alone ☐4. Extended family ☐7. Single-parent family (mother) ☐98. Prefer not to answer
☐2. Couple ☐5. Unrelated housemate ☐8. Other (Please specify): ☐99. Do not know
☐3. Couple with child(ren) ☐6. Single-parent family (father) ……

9. What is your source of income? (Check **ALL** that apply)

☐ 1. Full time employment
☐ 2. Part time employment
☐ 3. Student loan
☐ 4. Canadian Pension Plan (CPP)
☐ 5. Retirement income

Government Assistance:
☐6. Old Age Security (OAS)
☐7. Ontario Works (OW)
☐8. Employment Insurance (EI)
☐9. ODSP

☐ No income
☐ Other (Please specify):
……
☐ 98. Prefer not to answer
☐ 99. Do not know

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

☐1. $0.00-14,999 ($1,249/month or less;$7.69/hr or less)
☐2. $15,000-19,999 ($1,249-1,667/month;$7.69-10.26/hr)
☐3. $20,000-24,999 ($1,667-2,083/month;$10.26-12.82/hr)
☐4. $25,000-29,999 ($2,083-2,500/month;$12.82-15.38/hr)
☐5. $30,000-34,999 ($2,500-2,916/month;$15.38-17.95/hr)
☐6. $35,000-39,999 ($2,916-3,333/month;$17.95-20.51/hr)
☐7. $40,000-59,999 ($3,333-4,999/month;$20.51-30.77/hr)
☐8. over $60,000 (over $5,000/month;$30.77/hr and up)
☐98. Prefer not to answer
☐99. Do not know

11. How many people does this income support? …….. person(s) ☐98. Prefer not to answer ☐99. Do not know

12. In general, would you say your overall mental health is: (Check **ONE** only)

☐1. Excellent ☐2. Very good ☐3. Good ☐4. Fair ☐5. Poor

13. In general, would you say your overall physical health is: (Check **ONE** only)

☐1. Excellent ☐2. Very good ☐3. Good ☐4. Fair ☐5. Poor

14. How would you describe your sense of belonging to your community? (Check **ONE** only)

(Sense of belonging is feeling like you are part of something, connected and accepted)

☐1. Very strong ☐2. Somewhat strong ☐3. Somewhat weak ☐4. Very weak

The Anne Johnston Health Station-Tobias House Attendant Care is committed to protecting your privacy and the confidentiality of your personal health information. All information is collected in compliance with the Personal Health Information Protection Act, 2004 (PHIPA). In order to meet your health care needs, your personal information may be shared among staff and/or external providers involved in your circle of care. By signing below, you are indicating that you have read this statement and provide consent to the collection, use and sharing of your personal information for the purposes listed above. You are aware that you are providing consent voluntarily.

If you are client of the Mid Toronto Diabetes Education Program (MTDP), you consent to allow the MTDP to communicate with your family physician and to request a copy of your blood work for the purposes of diabetes management. Reports will be sent to your doctor.

Signature: _____ **Date completed:** ……/……../……
Day Month Year

For Staff Use Only

Population:
☐Barrier Free
☐Senior
☐Youth

Program/Clinic:
☐Chiropody
☐Diabetes
☐ECHO
☐Youth Can
☐PT
☐OT
☐Dietitian
☐Senior-on-site
☐SHHP
☐SB Transitions

Client Chart #:
Date:
Intake Appt. Date: _____
Assign to: _____
Staff initial: _____