NFCHC NIAGARA FALLS COMMUNITY HEALTH CENTRE

EMPOWERING INDIVIDUALS, STRENGTHENING COMMUNITY

Niagara Falls Community Health Centre – Intake Form

The information requested on this form will help us to provide you with the best care and services possible. The information will be kept confidential and only be seen by your healthcare provider(s). If used for evaluation purposes, your name, or any other personal identifiers, will not be included.

Personal Information					
Legal Name:	First		Last		
Preferred Name:	First		Last		
Birth Date:	mm/dd/yyyy ____/____/_____				
Phone Number: Contact allowed?	Cell ☐ Yes ☐ No	Home ☐ Yes ☐ No	Work ☐ Yes ☐ No		
	If you do not have a contact number, please provide an alternate contact information (i.e. community worker, shelter, friend, family):				
	Name	Phone Number			
Address:	Apt. #	Street			
	City	Province	Postal Code		
Health Card:	Number	Version Code	Expiry	Sex (as per Health Card) ☐ Male ☐ Female	
Email Address					
Emergency Contact:	Name	Phone Number			
	Address	Relationship			

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Insurance Status:	For clients who do not have OHIP or other Canadian provincial health insurance ☐ 3 Month Waiting ☐ OHIP eligible but no card	
Previous Health Care Provider:	Name	Phone Number
Which Pharmacy do you use?		
Gender:	☐ Female ☐ Male ☐ Intersex ☐ Trans – Female to Male ☐ Trans – Male to Female	☐ Two-Spirit ☐ Other (Please Specify): _____ ☐ Do not Know ☐ Prefer not to answer
Sexual Orientation:	☐ Bisexual ☐ Gay ☐ Heterosexual (“straight”) ☐ Lesbian ☐ Queer	☐ Two-Spirit ☐ Other (Please Specify): _____ ☐ Do not Know ☐ Prefer not to answer
How did you hear about NFCHC?	☐ Google ☐ Facebook ☐ Hospital ☐ Referred by other organization: _____	☐ Mobile Dental Bus ☐ NFCHC Sign ☐ Word of Mouth ☐ Other: _____

Social Cultural Information

Preferred Language:	☐ English ☐ French	☐ Other (please specify): _____
Country of Birth:		Year of Arrival in Canada:

Canadian Citizen?	☐ Yes ☐ No	**Permanent Resident?**	☐ Yes ☐ No	**Refugee?**	☐ Yes ☐ No

Race/Ethnicity:	Which of the following best describes your racial or ethnic group? ☐ Asian ☐ African American – Black ☐ Caucasian - White ☐ First Nations	☐ Other(s) (please specify): _____ ☐ Do not know ☐ Prefer not to answer

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Education and Income	
Highest Level of Education: (Only check one)	☐ Preschool ☐ Primary ☐ Secondary ☐ College ☐ University ☐ None ☐ Other (please specify): _____ ☐ Do not know ☐ Prefer not to answer
Source of Income:	
Combined annual household income:	From all sources living in the same residence ☐ 0 to $14,999 ☐ $15,000 to $19,999 ☐ $20,000 to $24,999 ☐ $25,000 to $29,999 ☐ $30,000 to $34,999 ☐ $35,000 to $39,999 ☐ > $40,000 ☐ Do not know ☐ Prefer not to answer Number of people supported by this income: _____
What kind of housing do you live in?	☐ Own home ☐ Rented apartment ☐ Shared rental ☐ Senior's Residence ☐ Shelter ☐ Supportive Housing ☐ Correctional Facility ☐ Homeless or without housing ☐ Other (please specify): _____ ☐ Prefer not to answer
What is your household composition?	☐ Living alone ☐ Couple ☐ Couple with children ☐ Single parent ☐ Extended Family ☐ Unrelated Housemate (Roommate) ☐ Other (please specify): _____ ☐ Prefer not to answer
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 or vision loss) ☐ Other (please specify): _____ ☐ None ☐ Do not know ☐ Prefer not to answer

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Services		
Which services are you registering for?	☐ Birth Certificate Clinic ☐ Dietitian ☐ Group	☐ Social Work ☐ Primary care (doctor, nurse practitioner, nurse)
Which services would you like to know more about?	☐ Birth Certificate Clinic ☐ Dietitian ☐ Group	☐ Social Work ☐ Primary care (doctor, nurse practitioner, nurse)

ALL of the above information is accurate to the best of my knowledge.

I consent and authorize the Niagara Falls Community Health Centre to provide me with primary health care service and support. I understand that the NFCHC will need to collect and use information about me for this purpose(s). I also understand that the NFCHC as an organization provides me with service and support and will need to share information among staff to achieve this. Lastly, I consent to the Niagara Falls Community Health Centre to contact me via telephone whenever it is needed.

I understand that this general consent for services and collection and use of information can be withdrawn in writing at any time but this action will impact the NFCHC's ability to provide services and care.

_____ _____

Client Signature Date (mm/dd/yyyy)