

CLIENT REGISTRATION FORM:

All Information Is Confidential

Please fill in as much as possible.

It will help us to provide health care services for you.

It will help us learn more about the health issues and well-being of the women we serve.

Thank you in advance for your cooperation.



2 Carlton Street Suite
500
Toronto ON
M5B 1J3
Tel: 416-593-7655
Fax: 416-593-5867

Date: _____

Chart #: _____

Name

Last name: _____

Preferred name: _____

First name: _____

Middle names: _____

Birthdate: _____ (day/month/year)

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

- | | |
|---|--|
| <input type="radio"/> 1. Female | <input type="radio"/> 6. Two-Spirit |
| <input type="radio"/> 2. Intersex | <input type="radio"/> 7. Other (Please specify): _____ |
| <input type="radio"/> 3. Male | <input type="radio"/> 98. Do not know |
| <input type="radio"/> 4. Trans-Female to Male | <input type="radio"/> 99. Prefer not to answer |
| <input type="radio"/> 5. Trans-Male to Female | |

2. What is your sexual orientation? Check **ONE** only.

- | | |
|--|--|
| <input type="radio"/> 1. Bisexual | <input type="radio"/> 6. Two-spirit |
| <input type="radio"/> 2. Gay | <input type="radio"/> 7. Other (please specify): _____ |
| <input type="radio"/> 3. Heterosexual ("straight") | <input type="radio"/> 98. Do not know |
| <input type="radio"/> 4. Lesbian | <input type="radio"/> 99. Prefer not to answer |
| <input type="radio"/> 5. Queer | |

3. Address

Street/Apartment #: _____

City/Postal Code: _____

4. Can you receive mail at the above address? Yes No

5. Telephone

Primary: _____ Alternate: _____

Can we leave a voice mail at the number(s) provided? Yes No

6. If we cannot phone or write, how can we reach you?

Please explain: _____

7. Health Insurance Coverage:

Interim Federal Health (IFH) program OHIP Other: _____

Health Insurance #: _____ Version code (if applicable): _____

8. Primary Care Provider (e.g. family doctor, nurse practitioner etc.)

Name: _____ Telephone: _____

Address: _____

9. In case of emergency, who should we call?

Name: _____ Relationship: _____

Address: _____ Telephone: _____

10. Which of the following best describes your racial or ethnic group? Check ONE only

- 1. Asian-East (e.g., Chinese, Japanese, Korean)
- 2. Asian-South (e.g., Indian, Pakistani, Sri Lankan)
- 3. Asian-South East (e.g., Malaysian, Filipino, Vietnamese)
- 4. Black-African (e.g., Ghanaian, Kenyan, Somali)
- 5. Black-Caribbean (e.g., Barbadian, Jamaican)
- 6. Black-North American (e.g., Canadian, American)
- 7. First Nations
- 8. Indian-Caribbean (e.g., Guyanese with origins in India)
- 9. Indigenous | Aboriginal *not included elsewhere*
- 10. Inuit
- 11. Latin American (e.g., Argentinian, Chilean, Salvadoran)
- 12. Metis
- 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- 14. White-European (English, Italian, Portuguese, Russian)
- 15. White-North American (e.g., Canadian, American)
- 16. Mixed heritage (e.g., Black-African & White-North American)

Please specify: _____

- 17. Other(s)
Please specify: _____

- 98. Do not know
- 99. Prefer not to answer



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11. What language would you feel most comfortable speaking in with your health care provider? Check ONE

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

12. Do you need a cultural interpreter?

- Yes No Language (including ASL, dialect): _____

13. Were you born in Canada?

1. Yes 2. No 98. Do not know 99. Prefer not to answer

If **NO**, what year did you arrive in Canada? _____

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

- | | |
|---|---|
| <input type="radio"/> 1. Chronic illness | <input type="radio"/> 7. Sensory Disability (i.e. hearing or vision loss) |
| <input type="radio"/> 2. Developmental Disability | <input type="radio"/> 8. Other (please specify) _____ |
| <input type="radio"/> 3. Drug or Alcohol Dependence | <input type="radio"/> 9. None |
| <input type="radio"/> 4. Learning Disability | <input type="radio"/> 98. Do not know |
| <input type="radio"/> 5. Mental Illness | <input type="radio"/> 99. Prefer not to answer |
| <input type="radio"/> 6. Physical Disability | |

15. What best describes the household you live in now?

- Couple with child(ren)
- Couple without child(ren)
- Live alone
- Siblings
- Extended family
- Unrelated housemates
- Grandparent(s) with grandchild(ren)
- Single parent family (mother head)
- Single parent (father head)
- Hostel | Shelter
- Street | Squat
- Nursing Home
- Other

16. What is your total family income before taxes last year? Check ONE only

- 1. \$0-\$14,999
- 2. \$15,000-\$19,999
- 3. \$20,000-\$24,999
- 4. \$25,000-\$29,999
- 5. \$30,000-\$34,999
- 6. \$35,000-\$39,999
- 7. \$40,000-\$59,999
- 8. \$60,000 or more
- 98. Do not know
- 99. Prefer not to answer

17. How many people are supported by this income? (Including out of country dependants)

18. What is highest level of formal education you have completed?

- Elementary (grades 1-8)
- High School (grades 9-12)
- University, Community College Trade School Apprenticeship
- No formal education
- other (specify): _____

19. How did you find out about us? Please specify

- Friend
- Family member
- School
- Community
- Health Centre
- Public Health Nurse
- Doctor
- Hospital
- Media
- Other: _____



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**20. How would you describe your sense of belonging to your community?
(Sense of belonging is feeling like you are part of something, connected and accepted)?**
(check one only)

- Very Strong
- Somewhat strong
- Somewhat weak
- Very Weak

21. In general, would you say your overall physical health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

22. In general, would you say your overall mental health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

23. If you would like to receive occasional updates about our programs, services, and other opportunities, please print your email address: _____

I consent to receiving emails about programs, services and other promotional activities at Women's health in Women's hands Community Health Centre. I understand that I can unsubscribe at any time.