The Four Villages
Community Health Centre
Working Together for Whole Health

Client Registration Form

Adults 18 years and over

Four Villages is required by its funder to collect the information below. This information will only be seen by your health care team and will be kept confidential like all your other health care information. It will be used to increase access to services and improve quality of care. **Please complete every field.** Thank you.

Legal Name: _____
First Name Last Name

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

Address: _____
Apartment # Building/House # Street Name

_____
City Province Postal Code

Preferred Phone Number: _____
☐ Home ☐ Business ☐ Mobile

Can we leave a detailed message? ☐ Yes ☐ No

Other Phone Number(s): _____
☐ Home ☐ Business ☐ Mobile

Email Address: _____

Do you have any special requests about how we contact you?

_____

What is the sex on your OHIP card? ☐ M ☐ F ☐ Prefer not to answer

Please enter your OHIP / IFH / other provincial health insurance number below:

_____ _____ _____ / ____ / _____
Version Code Exp. (year/month/day)

If you do NOT have OHIP, do you have other health insurance? ☐ Yes ☐ No
(e.g. IFH, other provincial health insurance)

If no, are you in the 3 month waiting period? ☐ Yes ☐ No

Please list any known allergies: _____

Do you have an epi-pen? ☐ Yes ☐ No

_____

Emergency Contact:

Name

_____ _____

Phone Number Relationship to You

Spouse / Partner: _____ _____

Name Phone Number

In the past month, was there any day when you or anyone in your family went hungry because you did not have enough money for food?

☐ Yes ☐ No

1. **What is your gender?** Check ONE only.
   - ☐ Male
   - ☐ Female
   - ☐ Intersex
   - ☐ Trans – Female to Male
   - ☐ Trans – Male to Female
   - ☐ Two-Spirit
   - ☐ Other (Please specify): _____
   - ☐ Do not know
   - ☐ Prefer not to answer

2. **What is your sexual orientation?** Check ONE only.
   - ☐ Bisexual
   - ☐ Gay
   - ☐ Heterosexual (“straight”)
   - ☐ Lesbian
   - ☐ Queer
   - ☐ Two-Spirit
   - ☐ Other (Please specify): _____
   - ☐ Do not know
   - ☐ Prefer not to answer

3. **What is the highest level of education you have completed?** Check ONE only.
   - ☐ Primary (grades 1 - 8)
   - ☐ Secondary or equivalent (grades 9 - 12/13)
   - ☐ College
   - ☐ University Bachelor’s
   - ☐ University Post-Graduate
   - ☐ No formal education
   - ☐ Other (Specify): _____
   - ☐ Prefer not to answer
   - ☐ Do not know

4. **What was your total family income before taxes last year?** Check ONE only.
   - ☐ $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 to $59,999
   - ☐ $60,000 to $89,999
   - ☐ $90,000 to $119,999
   - ☐ $120,000 to $149,999
   - ☐ $150,000 or more
   - ☐ Do not know
   - ☐ Prefer not to answer

5. **How many people does this income support?**

   _____ person(s)

   - ☐ Prefer not to answer
   - ☐ Do not know

6. What is your current household composition? Check ONE only.

- ☐ Couple with children
- ☐ Couple without children
- ☐ Sole member
- ☐ Grandparents with grandchildren
- ☐ Extended family
- ☐ Unrelated housemates
- ☐ Siblings
- ☐ Single parent
- ☐ Other
- ☐ Prefer not to answer

7. What is your current housing situation? Check ONE only.

- ☐ Not homeless
- ☐ Homeless/no address
- ☐ Shelter
- ☐ Other temporary

8. What is your first language, or "mother tongue"?

☐ English ☐ French Other: _____

9. In what language would you feel most comfortable speaking to your health-care provider?

☐ English ☐ French Other: _____

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

- ☐ Asian – East (e.g., Chinese, Japanese, Korean)
- ☐ Asian – South (e.g., Indian, Pakistani, Sri Lankan)
- ☐ Asian – South East (e.g., Malaysian, Filipino, Vietnamese)
- ☐ Black – African (e.g., Ghanaian, Kenyan, Somali)
- ☐ Black – Caribbean (e.g., Barbadian, Jamaican)
- ☐ Black – North American (e.g., Canadian, American)
- ☐ First Nations
- ☐ Indian – Caribbean (e.g., Guyanese with origins in India)
- ☐ Indigenous/Aboriginal
- ☐ Inuit
- ☐ Latin American (e.g., Argentinean, Chilean, Salvadoran)
- ☐ Métis
- ☐ Middle Eastern (e.g., Egyptian, Iranian, Lebanese)
- ☐ White – European (e.g., English, Italian, Portuguese, Russian)
- ☐ White – North American (e.g., Canadian, American)
- ☐ Mixed heritage (e.g., Black – African & White – North American) (Please specify):

  _____
- ☐ Other(s) (Please specify):

  _____
- ☐ Do not know
- ☐ Prefer not to answer

11. Were you born in Canada?

☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

If NO, in what country were you born? _____

What year did you arrive in Canada? _____

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

- ☐ None
- ☐ 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): _____
- ☐ Do not know
- ☐ Prefer not to answer

13. 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
- ☐ Prefer not to answer
- ☐ Do not know

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

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Do not know
- ☐ Prefer not to answer

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

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Do not know
- ☐ Prefer not to answer

Please email this completed form to kassandra@4villages.on.ca

The Four Villages
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Program Participation Waiver
for Physical Activity

1. Have you exercised in the past six months? ☐ Yes ☐ No

2. Do you have any of the following conditions?
   - ☐ Diabetes
   - ☐ Renal failure
   - ☐ Cardiovascular disease
   - ☐ Other condition that may affect your ability to participate in the program: _____

3. Do you experience any of the following with exercise?
   - ☐ Shortness of breath
   - ☐ Dizziness
   - ☐ Chest pain

I understand and agree that The Four Villages Community Health Centre (Four Villages) will not have or assume any financial responsibility for any injury I, or any children in my care, may suffer during or resulting from participation in this program.

_____ _____
Name of Client Date

_____ _____
Signature of Client Signature of Staff Witness

The Four Villages
Community Health Centre
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Photo Consent

I give my permission to The Four Villages Community Health Centre (Four Villages) to use my photograph and my child's photograph (if applicable) in their Annual Report to the Community or any other publications and promotional materials which Four Villages may produce in the future.

_____ _____
Name of Client or Parent/Guardian Date

_____ _____
Signature of Client or Parent/Guardian Signature of Staff Witness

_____
Names of children / dependents to which this consent applies

Please email this completed form to kassandra@4villages.on.ca