

Client Registration Form

Youth 13 to 17 years

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

Please list any known allergies: _____

Do you have an epi-pen? Yes No

Name of Parent/Guardian: _____

Phone Number

Relationship to You

Name of Parent/Guardian: _____

Phone Number

Relationship to You

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 Trans – Female to Male Other (Please specify): _____
 Female Trans – Male to Female _____
 Intersex Two-Spirit Do not know
 Prefer not to answer

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

- Bisexual Two-Spirit
 Gay Other (Please specify): _____
 Heterosexual (“straight”) Do not know
 Lesbian Prefer not to answer
 Queer

3. What is the highest level of education you have completed? Check ONE only.

- Primary (grades 1 - 8) University Post-Graduate
 Secondary or equivalent (grades 9 - 12/13) No formal education
 College Other (Specify): _____
 University Bachelor’s 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 \$35,000 to \$39,999 \$120,000 to \$149,999
 \$15,000 to \$19,999 \$40,000 to \$59,999 \$150,000 or more
 \$20,000 to \$24,999 \$60,000 to \$89,999 Do not know
 \$25,000 to \$29,999 \$90,000 to \$119,999 Prefer not to answer
 \$30,000 to \$34,999

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.

- | | |
|----------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Couple with children | <input type="checkbox"/> Unrelated housemates |
| <input type="checkbox"/> Couple without children | <input type="checkbox"/> Siblings |
| <input type="checkbox"/> Sole member | <input type="checkbox"/> Single parent |
| <input type="checkbox"/> Grandparents with grandchildren | <input type="checkbox"/> Other |
| <input type="checkbox"/> Extended family | <input type="checkbox"/> Prefer not to answer |

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

- | | |
|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Not homeless | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Homeless/no address | <input type="checkbox"/> 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.

- | | |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Asian – East (e.g., Chinese, Japanese, Korean) | <input type="checkbox"/> Latin American (e.g., Argentinean, Chilean, Salvadoran) |
| <input type="checkbox"/> Asian – South (e.g., Indian, Pakistani, Sri Lankan) | <input type="checkbox"/> Métis |
| <input type="checkbox"/> Asian – South East (e.g., Malaysian, Filipino, Vietnamese) | <input type="checkbox"/> Middle Eastern (e.g., Egyptian, Iranian, Lebanese) |
| <input type="checkbox"/> Black – African (e.g., Ghanaian, Kenyan, Somali) | <input type="checkbox"/> White – European (e.g., English, Italian, Portuguese, Russian) |
| <input type="checkbox"/> Black – Caribbean (e.g., Barbadian, Jamaican) | <input type="checkbox"/> White – North American (e.g., Canadian, American) |
| <input type="checkbox"/> Black – North American (e.g., Canadian, American) | <input type="checkbox"/> Mixed heritage (e.g., Black – African & White – North American) (Please specify):
_____ |
| <input type="checkbox"/> First Nations | <input type="checkbox"/> Other(s) (Please specify):
_____ |
| <input type="checkbox"/> Indian – Caribbean (e.g., Guyanese with origins in India) | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Indigenous/Aboriginal | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Inuit | |

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.

- | | |
|-----------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Sensory disability (i.e. hearing or vision loss) |
| <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Other (Please specify): _____ |
| <input type="checkbox"/> Drug or alcohol dependence | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Mental illness | |

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.

- | | | |
|------------------------------------------|----------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Very strong | <input type="checkbox"/> Somewhat weak | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Somewhat strong | <input type="checkbox"/> Very weak | <input type="checkbox"/> Do not know |

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

- | | | | |
|------------------------------------|-------------------------------|--------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Poor | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Fair | <input type="checkbox"/> Do not know | |

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

- | | | | |
|------------------------------------|-------------------------------|--------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Poor | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Fair | <input type="checkbox"/> Do not know | |

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

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
 - Heart condition: _____
 - 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 or Parent/Guardian	Date
Signature of Client or Parent/Guardian	Signature of Staff Witness
Names of children / dependents to which this consent applies	

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	

