

**VCHC GENERAL ONSITE CLIENT REGISTRATION FORM**

VCHC is a not-for-profit, community-governed organization that adheres to the Ontario Human Rights Code. We welcome and are inclusive to people of all races, ethnic origins, religions, abilities, sexual orientations, gender identities and expression and we do not make any assumptions. VCHC collects socio-demographic information from clients to find out who we are serving, and this helps guide the planning of programs and services to better meet the needs of our clients and community at large. The information you provide on the registration form will remain confidential and will be treated with respect; and in accordance with our privacy policies and the Personal Health Information Protection Act.

PERSONAL INFORMATION		
Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms.		Gender at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Last name:		First name:
Preferred Name:		Preferred Pronoun:
Marital status:		Date of birth (DD/MM/YYYY):
In what language do you feel most comfortable speaking with your healthcare provider? (Check <u>one</u> only)		
<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Urdu <input type="checkbox"/> Other _____		
Do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Citizenship: <input type="checkbox"/> Canadian <input type="checkbox"/> Landed Immigrant <input type="checkbox"/> Refugee <input type="checkbox"/> Other		
Were you born in Canada?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know <input type="checkbox"/> Prefer not to answer		
If no, when did you arrive in Canada? (DD/MM/YYYY)		If no, what country were you born in _____
Health card #:	Version code:	EXP date:
Interim Federal Health #:		EXP date:
Un-insured: <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when is your health card expected?	
ADDRESS AND CONTACT INFORMATION		
Street:		APT #:
City:	Province:	Postal code:
<input type="checkbox"/> HOMELESS STATUS <input type="checkbox"/> SHELTER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT		
Home #:	Can VCHC leave a message? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Mobile #:	Can VCHC leave a message? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Please indicate whom we should contact if VCHC Staff is unable to reach you:		
NAME:		PHONE #:
<b>Your Consent</b> <input type="checkbox"/> Yes, I give consent to receive emails from Vaughan Community Health Centre		
EMAIL: _____		

**EMERGENCY CONTACT INFORMATION**

Emergency Contact Name:

Relationship:

Emergency Contact's Phone #:

 Can VCHC leave a message?  YES  NO

**IF THIS CLIENT IS A CHILD (UNDER 14 YEARS OLD), PLEASE PROVIDE PARENT/GUARDIAN'S INFORMATION**

Parent/guardian's name:

Phone #:

 Is there a custodial agreement?  YES  NO

If yes, please provide details: \_\_\_\_\_

**Do you have any of the following? (Check all that apply) DISABILITIES – HEALTH CONDITIONS**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> 01. Chronic illness          | <input type="checkbox"/> 04. Learning disability | <input type="checkbox"/> 07. Sensory disability           | <input type="checkbox"/> 09. None                 |
| <input type="checkbox"/> 02. Developmental disability | <input type="checkbox"/> 05. Mental illness      | <input type="checkbox"/> 08. Other (Please specify) _____ | <input type="checkbox"/> 98. Do not know          |
| <input type="checkbox"/> 03. Drug/alcohol dependence  | <input type="checkbox"/> 06. Physical disability |   | <input type="checkbox"/> 99. Prefer not to answer |

**ACCESSIBILITY INFORMATION**
**PLEASE TELL US IF YOU HAVE SPECIAL NEEDS OR CHOOSE FROM THE FOLLOWING LIST:**

- |  |                                       |   |                                      |  |                               |
|--|---------------------------------------|---|--------------------------------------|--|-------------------------------|
| <input type="checkbox"/> Caregiver/family driver | <input type="checkbox"/> Home bound   | <input type="checkbox"/> Mobility Plus        | <input type="checkbox"/> Wheelchair  | <input type="checkbox"/> YRT bus tickets | <input type="checkbox"/> None |
| <input type="checkbox"/> Hearing devices         | <input type="checkbox"/> Living alone | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Do not know | <input type="checkbox"/> Other _____     |                               |

**SOCIO-DEMOGRAPHIC INFORMATION**
**1. Which of the following best describes your racial or ethnic group? (Check one only)**

- |  |  |
|--|--|
| <input type="checkbox"/> 01. Asian – East (e.g. China, Japan, Korea)                     | <input type="checkbox"/> 11. Latin American (e.g. Argentina, Brazil, Columbia)             |
| <input type="checkbox"/> 02. Asian - South (e.g. India, Pakistan, Bangladesh, Sri Lanka) | <input type="checkbox"/> 12. Métis   |
| <input type="checkbox"/> 03. Asian – Southeast (e.g. Malaysia, Philippines, Vietnam)     | <input type="checkbox"/> 13. Middle eastern (e.g. Syria, Iran, Lebanon)                    |
| <input type="checkbox"/> 04. Black – African (e.g. Ghana, Kenya, Somalia)                | <input type="checkbox"/> 14. White – European (e.g. UK, Portugal, Italy, Russian, Ukraine) |
| <input type="checkbox"/> 05. Black – Caribbean (e.g. Barbados, Jamaica)                  | <input type="checkbox"/> 15. White – North American (e.g. Canada , USA)                    |
| <input type="checkbox"/> 06. Black – North American (e.g. Canada , USA)                  | <input type="checkbox"/> 16. Mixed heritage (Please specify) _____                         |
| <input type="checkbox"/> 07. First Nations   | <input type="checkbox"/> 17. Other (Please specify) _____                                  |
| <input type="checkbox"/> 08. Indian – Caribbean (e.g. Guyana), Trinidad and Tobago)      | <input type="checkbox"/> 98. Do not know   |
| <input type="checkbox"/> 09. Indigenous/aboriginal                                       | <input type="checkbox"/> 99. Prefer not to answer  |
| <input type="checkbox"/> 10. Inuit   |  |

**2. What is your gender? (Check one only) GENDER**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> 01. Female   | <input type="checkbox"/> 04. Transgender (Female to Male) | <input type="checkbox"/> 07. Other _____          |
| <input type="checkbox"/> 02. Intersex | <input type="checkbox"/> 05. Transgender (Male to Female) | <input type="checkbox"/> 98. Do not know          |
| <input type="checkbox"/> 03. Male     | <input type="checkbox"/> 06. Two-Spirit                   | <input type="checkbox"/> 99. Prefer not to answer |

**3. What is your sexual orientation? (Check one only) SEXUAL ORIENTATION**

<input type="checkbox"/> 01. Bisexual	<input type="checkbox"/> 04. Lesbian	<input type="checkbox"/> 07. Other (Please specify) _____
<input type="checkbox"/> 02. Gay	<input type="checkbox"/> 05. Queer	<input type="checkbox"/> 98. Do not know
<input type="checkbox"/> 03. Heterosexual	<input type="checkbox"/> 06. Two-Spirit	<input type="checkbox"/> 99. Prefer not to answer

**4. What was your total household income before taxes last year?**

<input type="checkbox"/> \$0 - \$14,999	<input type="checkbox"/> \$35,000 - \$39,999	<input type="checkbox"/> \$150,000 or more
<input type="checkbox"/> \$15,000 - \$19,999	<input type="checkbox"/> \$40,000 - \$59,999	<input type="checkbox"/> 98. Do not know
<input type="checkbox"/> \$20,000 - \$24,999	<input type="checkbox"/> \$60,000 - \$89,999	<input type="checkbox"/> 99. Do not want to answer
<input type="checkbox"/> \$25,000 - \$29,999	<input type="checkbox"/> \$90,000 to \$119,999	
<input type="checkbox"/> \$30,000 - \$34,999	<input type="checkbox"/> \$120,000 to \$149,999	

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

Including dependent parents, children, support payments etc. this income supports \_\_\_\_\_ people.

Do not know       Prefer not to answer

**6. What is your current household composition?**

<input type="checkbox"/> 01 Mother, father, children	<input type="checkbox"/> 05 Extended family	<input type="checkbox"/> 09 Single parent (father head)
<input type="checkbox"/> 02 Couple without children	<input type="checkbox"/> 06 Unrelated housemate(s)	<input type="checkbox"/> 10 Other
<input type="checkbox"/> 03 Sole member	<input type="checkbox"/> 07 Sibling(s)	<input type="checkbox"/> 11 Same sex couple
<input type="checkbox"/> 04 Grandparent(s) with grandchild(ren)	<input type="checkbox"/> 08 Single parent (mother head)	<input type="checkbox"/> 98 Do not know
		<input type="checkbox"/> 99 Do not want to answer

**7. What is the highest education level you have completed? (Check one only)**

<input type="checkbox"/> 01 Primary or equivalent (Grade 1-8)	<input type="checkbox"/> 04 Too young for primary completion	<input type="checkbox"/> 98 Do not know
<input type="checkbox"/> 02 Secondary or equivalent (Grade 9-12)	<input type="checkbox"/> 05 No formal education	<input type="checkbox"/> 99 Do not want to answer
<input type="checkbox"/> 03 Post-Secondary or equivalent	<input type="checkbox"/> 06 Other _____	

**8. In general, would you say your mental health is:**

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

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

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

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

Very strong     Somewhat strong     Somewhat weak     Very Weak     Do not know     Prefer not to answer

**HOW DID YOU LEARN ABOUT VCHC'S SERVICES?**

<input type="checkbox"/> Ad in local newspaper	<input type="checkbox"/> Family doctor/specialist	<input type="checkbox"/> Friend/family member	<input type="checkbox"/> VCHC social media
<input type="checkbox"/> Community organization:	<input type="checkbox"/> Flyer posted at VCHC	<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> VCHC staff
<input type="checkbox"/> Do not want to answer	<input type="checkbox"/> Flyer posted in the community	_____	<input type="checkbox"/> VCHC website

VCHC Staff Responsible: \_\_\_\_\_ Date Collected: \_\_\_\_\_ Location: \_\_\_\_\_