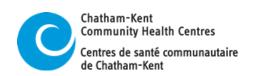


CLIENT APPLICATION

The Chatham-Kent Community Health Centres (CKCHC) accepts new clients based on our target population criteria. Please answer all questions to the best of your knowledge. This form is protected and confidential once completed and submitted

LAST NAME:		GIVEN (FIRST)	NAME: MIDD		DLE NAME:	ALIAS (if do not go by given name):		BIRTH DATE: dd/mm/yyyy	
ADDRESS: street number and name					APARTMENT:		CITY/TOWN:		
PROVINCE:	POSTAL C	CODE:	HOME PHONE NUMBER:				CELL PHONE NUMBER:		
HEALTH CARD NUMBE	L R:		Do you cur	rently	have a Docto	or or	Do you have a family member from the		
			Nurse Practitioner?				same household that is already a client		
VERSION CODE: EXPIRY DATE:			Yes No No				at the CKCHC? Yes No		
Do Not Have a Health Card			What is your current/previous Doctor's						
Are you a Canadian cit	or Nurse Practitioner's name?				If Yes, what is their name?				
Yes No No									
List all children under the age of 16, living at your address and will be attending the Chatham-Kent Community Health Centres. Please fill out a separate application for family members over 16 years old.									
NAME BIRTH D			ATE HEALTH CARD NUMB					SEX	RELATIONSHIP
		dd/mm/y	yyy please include version code and				expiry date		
Do you have communication problems that make accessing health services difficult? Yes No									
Do you require a translator? Yes No									
What is your mother tongue (first language learned)? English French Other please specify:									
If your mother tongue is not English or French, are you most comfortable with English or French? English French									
What language are you most comfortable using?									
English French American Sign Language Arabic Low German Spanish									
Other please specify:									
What is your annual income? \$\ \\$0 - \\$19,999 \\$20,000 - \\$29,999 \\$30,000 - \\$39,999 \partial \partial \text{possibility you could be} \text{community as a seasonal}									
\$40,000 – \$59,999 greater than \$60,000 pregnant? worker?									
Do Not Know Prefer Not to Answer Yes No Yes No Yes No									
Does 2/3 of your income go towards food and housing? Yes No No									
Race/Ethnic Origin: Indigenous Inuit Metis Asian Black Latin American Middle Eastern									
White Other please specify:									
Gender: Female Male Intersex Trans – Female to Male Trans – Male to Female									
Two-Spirit Other please specify:									



Sexual Orientation: Heterosexual (Straight) Gay Lesbian Bisexual Queer Two-Spirit										
Other please specify:										
Are you currently or have you seen a Therapist or Counsellor? Yes No If Yes, please list name and year last seen:										
Are you currently or have you seen any Specialists? Yes No Seen any Specialists? If Yes, please list name(s) and year last seen:										
PLEASE LIST ALL MEDICATIONS (Prescribed and Over the Counter) or ATTACH A CURRENT LIST FROM YOUR PHARMACY										
(For rapid referral applicants, attach a current medication list from pharmacy) NAME DOSE DIRECTIONS										
							- 10112			
What is the name of the pharmacy you go to?										
	Y OF THE FOLLOWI				ly:					
CHRONIC ILLNESS:	High Blood Pressure			Panic AC Disorder		ADDIO	CTIONS:	Autism	SENSORY DISABILITY:	
Diabetes	High Cholesterol	Bipolar Disorder		Psychosis		Alcoh Addic		Brain Injury	Hearing Impairment	
COPD	Arthritis	Depression		OCD		Drug Addic	tion	PHYSICAL DISABILITY:	Vision Impairment	
CHF	Sleep Apnea	Anxiety		LEARNING DISABILITY	·:	DEVE	LOPMENTAL BILITY:	Cerebral Palsy	NONE	
Heart Disease	Asthma	Schizophren	ia	Dyslexia		ADHD		Muscular Dystrophy	DO NOT KNOW	
If you have a disea	ase, disability or dis	order that wa	as not	listed abov	e, plea	se list k	elow:		•	
RAPID REFERRAL – This section is to be completed by a person from an approved rapid referral organization only. *Please fill out section completely*										
Referral Source:		1	icase I	iii out sect	וטוו נטו	iibierei	y			
Name:	Name: Phone Number: Ext:									
Organization: CKHA - MHAP CMHA ACTT ACCESS Open Minds Dr. Gopidasan (requires referral from PCP)										
Name of Client's Psychiatrist:										
Is your Client aware that this referral has been made? Yes No Is your Client stable? Yes No										
Client must have a diagnosed SMI and be without a Doctor or Nurse Practitioner to qualify. Please ensure a diagnosis has been checked above										