Chatham-Kent
Community Health Centres

Centres de santé communautaire
de Chatham-Kent

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:**	**MIDDLE NAME:**	**ALIAS (if do not go by given name):**	**BIRTH DATE:** dd/mm/yyyy

ADDRESS: street number and name	**APARTMENT:**	**CITY/TOWN:**

PROVINCE:	**POSTAL CODE:**	**HOME PHONE NUMBER:**	**CELL PHONE NUMBER:**

HEALTH CARD NUMBER:

VERSION CODE: **EXPIRY DATE:**

Do Not Have a Health Card ☐

Are you a Canadian citizen?

Yes ☐ No ☐

Do you currently have a Doctor or Nurse Practitioner?

Yes ☐ No ☐

What is your current/previous Doctor's or Nurse Practitioner's name?

_____

_____

Do you have a family member from the same household that is already a client at the CKCHC?

Yes ☐ No ☐

If Yes, what is their name?

_____

_____

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 DATE dd/mm/yyyy	HEALTH CARD NUMBER please include version code and expiry date	SEX	RELATIONSHIP

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 ☐

$40,000 – $59,999 ☐ greater than $60,000 ☐

Do Not Know ☐ Prefer Not to Answer ☐

Does 2/3 of your income go towards food and housing?

Yes ☐ No ☐

Are you or is there a possibility you could be pregnant?

Yes ☐ No ☐

Are you temporarily in the community as a seasonal worker?

Yes ☐ 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: _____

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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 ☐

Are you currently or have you seen a Psychiatrist?
Yes ☐ No ☐
If Yes, please list name and year last seen:
_____

Are you currently or have you seen any Specialists?
Yes ☐ No ☐

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

What is the name of the pharmacy you go to? _____

DO YOU HAVE ANY OF THE FOLLOWING? Please check **ALL** that apply:

CHRONIC ILLNESS:	High Blood Pressure ☐	**MENTAL DISORDER:**	Panic Disorder ☐	**ADDICTIONS:**	Autism ☐	**SENSORY DISABILITY:**
Diabetes ☐	High Cholesterol ☐	Bipolar Disorder ☐	Psychosis ☐	Alcohol Addiction ☐	Brain Injury ☐	Hearing Impairment ☐
COPD ☐	Arthritis ☐	Depression ☐	OCD ☐	Drug Addiction ☐	**PHYSICAL DISABILITY:**	Vision Impairment ☐
CHF ☐	Sleep Apnea ☐	Anxiety ☐	**LEARNING DISABILITY:**	**DEVELOPMENTAL DISABILITY:**	Cerebral Palsy ☐	**NONE** ☐
Heart Disease ☐	Asthma ☐	Schizophrenia ☐	Dyslexia ☐	ADHD ☐	Muscular Dystrophy ☐	**DO NOT KNOW** ☐

If you have a disease, disability or disorder that was not listed above, please list below:
_____
_____

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:

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****