**INTAKE FORM:**
**All Information Is Confidential**
**The information requested allows Women’s Health in Women’s Hands to evaluate each applicant for eligibility for our services**; therefore, we request you complete this document in its entirety. Not filling out the form in its entirety will delay the review process.

Do not send this form through fax or email, it will not be accepted. Do not attach your medical chart to the application, it will not be accepted.

If you are applying for a primary care provider, please note you cannot have a primary care provider at a different clinic at the same time.

Please return the completed form to the centre, in person.
Thank you in advance for your cooperation.

**Date:**

**Name**

Last name: Preferred name:

First name: Middle names:

**Date of Birth:**

1. **What is your gender?** Check **ONE** only

|  |  |
| --- | --- |
| * 1. Female
 | * 6. Two-Spirit
 |
| * 2. Intersex
 | * 7. Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * 3. Male
 | * 98. Do not know
 |
| * 4. Trans-Female to Male
 | * 99. Prefer not to answer
 |
| * 5. Trans-Male to Female
 |  |

1. **Telephone**

Primary:

Alternate:

1. **Can we leave a voice mail at the number(s) provided?** Yes No
2. **Email Address:**

**5. Health Insurance Coverage:**

Interim Federal Health (IFH) program OHIP Other:

Health Insurance #: Version code (if applicable):

**6. Do you reside in Canada? (*We only see residents of Ontario*)** ⭘Yes ⭘ No

**7. Do you have a Primary Care Provider (e.g. family doctor, nurse practitioner etc.)** Yes  No 

**8. If you currently have a primary care provider do you wish to transfer you care?** Yes  No 

**9. Are you receiving service at another Community Health Centre?  Yes No**

**If yes, which one and what services are you receiving?**

**Name of Community Health Centre**: **Service(s):**

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

|  |
| --- |
| * 1. Asian-East *(e.g., Chinese, Japanese, Korean)*
 |
| * 2. Asian-South *(e.g., Indian, Pakistani, Sri Lankan)*
 |
| * 3. Asian-South East *(e.g., Malaysian, Filipino, Vietnamese)*
 |
| * 4. Black-African *(e.g., Ghanaian, Kenyan, Somali)*
 |
| * 5. Black-Caribbean *(e.g., Barbadian, Jamaican)*
 |
| * 6. Black-North American *(e.g., Canadian, American)*
 |
| * 7. First Nations
 |
| * 8. Indian-Caribbean *(e.g., Guyanese with origins in India)*
 |
| * 9. Indigenous | Aboriginal *not included elsewhere*
 |
| * 10. Inuit
 |
| * 11. Latin American (e.g., Argentinian, Chilean, Salvadoran)
 |
| * 12. Metis
 |
| * 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
 |
| * 14. White-European (English, Italian, Portuguese, Russian
 |
| * 15. White-North American (e.g., Canadian, American)
 |
| * 16. Mixed heritage (e.g., Black-African & White-North American)
 |
| Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 17. Other(s)
 |
| Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 98. Do not know
 |
| * 99. Prefer not to answer
 |

**11. What language would you feel most comfortable speaking in with your health care provider?**

**12. Do you need a cultural interpreter?**

Yes  No  Language (including ASL, dialect):

**13. Are you currently pregnant?**

**If yes, how many weeks? (***We do not accept clients more than 20 weeks pregnant)*

**14. Please indicate the services you are interested in receiving:**

|  |
| --- |
| * Medical Services (Nurse practitioner/Family Doctor)
 |
|  |
| * Chiropody/foot care
 |
| * Dietician/Diabetes Care
 |
| * HIV Support, care and treatment for positive women
* Social Work
* Mental Health Therapy

|  |
| --- |
|  |

**15. How did you find out about us? Please specify**

|  |
| --- |
| * Friend
 |
| * Family member
 |
| * School
 |
| * Community
 |
| * Health Centre
 |
| * Public Health Nurse
 |
| * Doctor
 |
| * Hospital
 |
| * Media
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

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Name

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