ADULT REGISTRATION FORMS (14 YEARS AND UP) – PRIMARY CARE

Personal details – Mandatory section Please write the name as it appears on your health card					
Surname	First name	Date of birth dd / mm / yyyy	Identify as male ☐	Identify as female ☐	Identify as other ☐
Address		City		Postal Code	
Residential Telephone		Work Telephone		Cellular Telephone	
Email address:_____ CSCT uses email for some communications. You will receive an email consent form to complete after your registration.					
Health Card					
Card number		Version		Expiration date dd / mm / yyyy	
In case of emergency					
Contact person	Relation	Telephone 1	Telephone 2		
Pharmacy					
Name of your pharmacy		City			
Third party insurance					
Do you have insurance coverage? ☐ Yes ☐ No		Name of insurance provider			

CENTRE DE SANTÉ COMMUNAUTAIRE DE TIMMINS **SOINS PRIMAIRES**	
1500 Riverside Drive, Unit 58	
Timmins, ON, P4R 1A1	
(Timmins Square)	
TELEPHONE: 705-269-2728	
FAX: 705-269-2729	
Office hours **Monday to Friday** 9h to 12h - 13h to 16h	**Telephone services** **Monday to Thursday** 9h to 12h - 13h to 15h30 **Friday** 9h to 12h

Socio-demographic information – Mandatory section

Socio-economic

Gender identity:

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

Sexual orientation:

- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Queer
- ☐ Two-Spirit
- ☐ Other (Specify): _____
- ☐ Do not know
- ☐ Prefer not to answer

Highest education level attained

- ☐ Too young for primary completion
- ☐ Primary (grades 1-8)
- ☐ Secondary or equivalent
- ☐ College
- ☐ University Bachelor's
- ☐ University Post-Graduate
- ☐ No formal education
- ☐ Other (Specify): _____
- ☐ Do not know
- ☐ Prefer not to answer

Combined annual household income :

- ☐ 0$ to 14 999$
- ☐ 15 000$ to 19 999$
- ☐ 20 000$ to 24 999$
- ☐ 25 000$ to 29 999$
- ☐ 30 000$ to 34 999$
- ☐ 35 000$ to 39 999$
- ☐ 40 000$ to 59 999$
- ☐ 60 000$ to 89 999$
- ☐ 90 000$ to 119 999$
- ☐ 120 000$ to 149 999$
- ☐ 150 000$ or more
- ☐ Do not know
- ☐ Prefer not to answer

No. of people supported by income: _____

- ☐ Prefer not to answer

Homeless status:

- ☐ Not homeless
- ☐ Homeless/no address
- ☐ Shelter
- ☐ Other temporary housing

Current household composition:

- ☐ Couple with children
- ☐ Couple without child
- ☐ Sole member
- ☐ Grandparents with grandchild(ren)
- ☐ Extended family
- ☐ Unrelated housemates
- ☐ Siblings
- ☐ Single parent
- ☐ Do not know
- ☐ Prefer not to answer

Language

Spoken language (preferred)	**Language of origin:**
☐ French	☐ French
☐ English	☐ English
☐ Other: _____	☐ Other: _____
Official Canadian languages:	Other languages spoken:
☐ French	_____
☐ English	_____
If your language of origin is neither French nor English, in which of Canada's official languages are you more comfortable?	_____

Interpreter required for appointments: ☐ Yes ☐ No

Background

Racial or ethnic group:	**Country of origin:**
☐ Asian – East	☐ Canada
☐ Asian – South	☐ Other country (Specify): _____
☐ Asian – South East	Year of arrival in Canada: _____
☐ Black – African	
☐ Black – Caribbean	**Religion:**
☐ Black – North American	☐ Catholic
☐ First Nations	☐ Protestant
☐ Indian – Caribbean	☐ Christian Orthodox
☐ Indigenous/Aboriginal	☐ Christian
☐ Inuit	☐ Muslim
☐ Latin American	☐ Jewish
☐ Metis	☐ Buddhist
☐ Middle Eastern	☐ Mennonite
☐ White – European	☐ Hindu
☐ White – North American	☐ Sikh
☐ Mixed Heritage	☐ Eastern religion
☐ Other (Specify): _____	☐ No religious affiliation
☐ Do not know	☐ Other (Specify): _____
☐ Prefer not to answer	☐ Do not know
	☐ Prefer not to answer

Disability (check all that apply)

☐	None	☐	Physical disability
☐	Chronic illness	☐	Sensory disability
☐	Developmental disability	☐	Other: _____
☐	Drug or alcohol dependence	☐	Do not know
☐	Learning disability	☐	Prefer not to answer
☐	Mental illness		

Wellbeing

What is you sense of **belonging to the community**?

☐	Very Strong	☐	Somewhat Strong	☐	Somewhat weak	☐	Very weak	☐	Do not know	☐	Prefer not to answer

In general, how do you feel about the state of your **physical health?**

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

In general, how do you feel about the state of your **mental health?**

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

The CSCT is engaged to be sensitive to and prevent obstacles to accessibility to our programs and services for people with disabilities

Please indicate if you have any **special needs**:

☐	Deaf or hard of hearing	☐	Intellectual disability
☐	Mental health disorder	☐	Physical handicap / Motor deficiency
☐	Difficulty in speech and language	☐	Visual deficiency
☐	Assistance animal	☐	Difficulties with reading and writting

Centre de santé communautaire de Timmins

PERSONAL HEALTH FORM – ADULT (14 YEARS AND UP)

Surname	**First Name**	**Date of birth** dd/mm/yyyy
Name of your previous physician or nurse practitioner:		**Approximate date of your last appointment:**
Height (cm or feet):	**Weight (lbs or kg):**	

Personal Health		
Current and passed health problems (check all that apply) :		
☐ Stroke	☐ Emphysema or COPD	☐ Mental health disorders
☐ Anemia	☐ Epilepsy	☐ Positive TB skin test
☐ Anxiety	☐ Atrial fibrillation	☐ Attention or hyperactivity disorders
☐ Sleep Apnea	☐ High cholesterol	☐ Cardiac problems
☐ Arthritis	☐ High blood pressure	☐ Circulation problems
☐ Asthma	☐ Hepatitis	☐ Memory problems (dementia)
☐ Blood clots	☐ Migraines	☐ Blood disorders
☐ Drug or alcohol dependence	☐ Osteoporosis	☐ Varicella in childhood
☐ Depression	☐ Polyps of the colon	☐ Zona (shingles)
☐ Diabetes	☐ Problem with liver	☐ Other: _____
☐ Diverticulitis	☐ Problem with prostate	
☐ Cancer – Type: _____	☐ Problem with kidneys	
	☐ Problem with thyroid	

Are you followed by a specialist?

Name of specialist: _____ ☐ Currently ☐ In the past

Reason: _____

Name of specialist: _____ ☐ Currently ☐ In the past

Reason: _____

Surgeries or hospitalisations		
Type of surgery or reason for hospitalisation	Year	Hospital

Obstetrical history: (include numbers where applicable)	
Number of pregnancies:	Term births (after 37 weeks):
Miscarriage(s):	Premature births (before 37 weeks):
Abortion(s):	Living children at birth:
Complications:	

Immunisations: Specify date or approximate age.	**Please provide us with your immunisation booklet**		
	☐ Tetanus	☐ Flu shot	☐ Gardasil (HPV)
	☐ Pneumovax	☐ Shingrix/Zostavax	☐ Hepatitis A/B
	☐ Covid 19 Type: _____		

Medications: (include drops and prescribed creams/ointments) If you take many medications or narcotics, please provide us with a medication list from your pharmacy along with these forms, instead of filling the table below.		
Name	Dose	How many times a day
Non prescribed medications (vitamins, natural supplements and over the counter pain medications)		

Allergies: (medications, latex, or food allergens)	
Name	Reaction

LIFESTYLE HABITS

Exercise	Do you exercise regularly?		☐ Yes	☐ No	
	If yes, what type of exercise?				

Tabaco	**Do you smoke cigarettes or vape?**	☐ Never smoked	☐ Ex-smoker		
		☐ Current smoker	Pack(s) per /day: _____	Number of years: _____	
	Other types of tabaco	☐ Pipe	☐ Cigars	☐ Chewing tobacco	

Alcohol	Do you drink alcohol?	☐ No	☐ Yes	☐ Occasionally ☐ Regularly
	If you drink regularly, how many glasses per week?			

Drugs	Have you used any recreational drug in the pas 2 years? (including marijuana)	☐ Yes	☐ No
	Have you ever used recreational drugs with the use of a needle?	☐ Yes	☐ No

PREVENTION

Cancer screening			
Screening tests	**Year**	**Results**	
Cervical cancer screening (Pap Test)		□ Normal	□ Abnormal
Breast cancer screening (Mammogram)		□ Normal	□ Abnormal
Colorectal cancer screening (FIT or FOBT)		□ Normal	□ Abnormal
Colorectal cancer screening (Colonoscopy)		□ Normal	□ Abnormal

Routine health assessments	
	Year
Optometrist visit (vision test)	
Dental visit	
Blood tests (Diabetes and cholesterol tests)	
Foot Care (Diabetes)	
Diabetes Education (specify location):	
Mental health support (specify agency or therapist):	
Other routine assessments (specify):	

Personal health goals
Do you have any changes that you would like to make in your life when it comes to your health and wellbeing? If yes, which?
Which changes have you already made to present to achieve your health and wellbeing goals? (If applicable)
Do you need support to achieve these personal health goals?
What are obstacles that may prevent you from achieving your health and wellbeing goals?

Family medical history			
Family members		Age	Health problems (examples): diabetes, high blood pressure, high cholesterol, heart conditions, stroke, Cancer (type), mental health disorders, etc.
Mother	□ Living □ Deceased		
Père	□ Living □ Deceased		
Maternal grand mother	□ Living □ Deceased		
Maternal grand father	□ Living □ Deceased		
Paternal grand mother	□ Living □ Deceased		
Paternal grand father	□ Living □ Deceased		
Children	□ ___ Boys □ ___ Girls		
Siblings	□ ___ Brothers □ ___ Sisters		

Think of the future		
		Comments
Have you designated a Power of Attorney for Personal Care?	☐Yes ☐No	
If you cannot make decisions about your finances or your medical care, who do you confide in to make those decisions for you?	Name of person: _____ Relation to you: _____ Address: Telephone number :	
Have you established advanced directives when it comes to cardiac resuscitation, mechanical ventilation or other life saving interventions that you care provider should be aware of?	☐Yes ☐No	

ORIENTATION GUIDE

1. **Eligibility**
   - Ability to understand, read and write in French (ex: consent)
   - In the event that the client is unilingual, to be eligible for our services, he or she must have a link with an immediate family member (partner or child) of a client already registered with the Centre de santé Communautaire de Timmins (CSCTimmins).

2. **Becoming a client**
   - Please be advised that you are a client of CSCTimmins and not a client of a specific doctor or nurse practitioner.
   - Access to all members of the interdisciplinary team (ex. registered nurse, dietitian, social worker) for continuity of care as needed. This increases the accessibility of our services and this model is put into practice to better serve our clients and their identified needs.

3. **Interdisciplinary Team**
   - The CSCTimmins client will have access to all services in French in the primary care clinic as well as all community activities.
   - If you are not a primary care client, you still have access to community programs, activities and workshops.

4. **Appointments**
   - You must contact the office at least 24 hours prior to your appointment to notify the staff of your cancelation; not only for the clinic but for all service appointments.
   - If you are more than 15 minutes late for your scheduled appointment, your appointment will be canceled and considered a “no show”.
   - After your 3rd missed appointment without notification, a letter of notice will be sent to you by mail. If there is no response, your file will be closed. If you choose to contact us for services, your name will be added to our wait list to become a client.

5. **Prescription Renewal**
   - You should contact your pharmacy **1 to 2 weeks** prior to your medication running out for a refill.

I confirm that I have read and understand the Client Orientation Guide as well as the procedure listed. As a client of the Centre de santé communautaire de Timmins, I accept responsibility for the terms stated above and understand what this guide states.

Signature _____ **Date** _____

Print name _____

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF CLIENTS PERSONAL INFORMATION

The Centre de santé communautaire de Timmins (CSCT) recognizes the importance of protecting your personal information and commits to collect, use and disclose your personal information in a honest and legal way by implementing good personal information protection practices, including information given to a third party.

The CSCT collects, uses and discloses the information to:

- Provide and manage secure primary health care services;
- Establish and assure ongoing and effective health services;
- Communicate with other service providers (with your consent);
- Provide community and health promotion services;
- Inform certain funding bodies such as Ontario's Ministry of Health and Ministry of Long-Term Care and the Local Health Intergration Networks in order to contribute to the planning et management of the health care system;
- Evaluate and plan your health needs;
- Establish and maintain communication with you;
- Manage the administrative operations of the CSCT;
- Participate in the research to improve the quality of health services or use the data collected for specific reseach purposes;
- Respond to any other objective permitted or required by law (for exemple: reporting infectious diseases to Public Health).

You acknowledge that you have given an informed consent regarding the collection, use and disclosure of your personal information for the reasons listed above. If a new reason for the use or disclosure of your personal information appears, we will notify you and seek your consent beforehand.

You may ask to see and make changes to your personal information regarding your health. You can withdraw your consent to the use and disclose of your personal information at any time upon notice; at that time, the CSCT will explain how to proceed and the repercussions of your decision.

Please note that files of adults are destroyed after ten (10) years of inactivity.
I certify that I have received orientation regarding the services and programs offered by the CSCT.

Signature _____ **Date** _____

Printed name: _____