City Centre Health Care

A Community Health Centre Operated by CMHA-WECB

Intake/Referral Form

Name: ______________________________ **Today's Date:** ____________________
mm dd yyyy

Health Card #: ____________________ **Version**: ________ **Date of Birth**: ____________________
mm dd yyyy

Address: ____

City: ______________________ **Province**: _____ **Postal Code:** __________

Phone Number: (____) ______-_______ **Alternate Number:** (____) ______-_______

Instructions for Contacting Client: ____

Emergency Contact (include Phone #): ____

Referred by: ☐ **Self** ☐ **CMHA Worker** ________________ ☐ **Other** ________________

CRITERIA

☐ Do not have a family doctor at the time of presentation to the City Centre Health Care*

☐ Presently have a Family Doctor

*We serve adults, children, babies, and families without a family doctor who live in Windsor-Essex County.

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CCHC HEALTH SCREENING FORM
(Completed by client)

Name:____ **Today's Date:** ______________________

GENDER:

- Male
- Female
- Transgender (M-F , F-M)
- Two-Spirit
- Other
- Prefer not to answer
- Intersex

SEXUAL ORIENTATION:

- Bisexual
- Gay
- Heterosexual
- Lesbian
- Queer
- Two-Spirit
- Other____________________
- Do not know
- Prefer not to answer

RACIAL OR ETHNIC GROUP

- Asian (South/East/South East)
- Latin American
- First Nations
- White (European/North American)
- Indian-Caribbean
- Aboriginal/Indigenous
- Metis
- Middle Eastern
- Inuit
- Prefer not to say
- Mixed Heritage
- Other ________________
- Black (African/Caribbean/North American)

ANNUAL INCOME:		
$0 - $14,999	$15,000 - $19,000	$20,000 - $24,999
$25,000 - $29,999	$30,000 - $34,999	$35,000 - $39,999
$40,000 - $59,999	$60,000 or greater	ODSP / OW
I don't know	Prefer not to answer	

What medications are you taking *(including over the counter products, vitamins, products from health food store or drug store, etc. taken on a regular basis)*? **Please bring all medications with you on your first visit**

Name	Dose	How often?		Name	Dose	How Often?

Please list any drug allergies **and the reaction** that you had to the drug.

Drug	Reaction		Drug	Reaction

CMHA Windsor-Essex County Branch, 1400 Windsor Avenue, Windsor. Ontario NBX 3L9 Tel (519) 255-7440 Admin Fax (519) 255-7817 Community Support Services Fax (519) 971-0058 • CCHC Tel (519) 971-0116 • CCHC Fax (519) 252-5646

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FAMILY HISTORY

Does/did anyone in your family have any of the following conditions?

Condition	Yes	No	Age at diagnosis/Type
Breast Cancer			____________________
Colon Cancer			____________________
Prostate Cancer			____________________
Other Cancer			____________________
High Cholesterol			____________________
Heart Disease			____________________
Diabetes			____________________
Depression/Anxiety/Other			____________________
Other conditions			____________________

LIFESTYLE HISTORY

Have you ever smoked tobacco?

Yes No

If yes, how many cigarettes ___________Packs per day for________years.

Do you smoke cannabis?

If yes, how many/much ________________________

Do you drink alcohol?

If yes, how many drinks a day _______________________

Are your immunizations up to date? Don't know

Yes No

Have you ever taken illegal drugs? Please List ____.

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CCHC HEALTH SCREENING FORM
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MEDICAL HEALTH HISTORY

1. Have you ever had or been told you had any of the following conditions?:

Condition	Yes	No	Condition	Yes	No
Epilepsy/seizures	☐	☐	Bowel Disease	☐	☐
Fainting spells or dizziness	☐	☐	Diabetes	☐	☐

Condition	Yes	No	Condition	Yes	No
Headaches	☐	☐	Ulcers/vomiting blood	☐	☐
Backache/Neck ache, injury to back or neck	☐	☐	Gall bladder disease	☐	☐
High Blood pressure	☐	☐	Liver disease/hepatitis/jaundice	☐	☐
Arthritis, rheumatism	☐	☐	Cancer | Type:	☐	☐
Heart murmur	☐	☐	Sexually transmitted disease	☐	☐
Heart attack, angina, chest pain	☐	☐	Alcoholism or addiction	☐	☐
Other heart problems	☐	☐	Hemorrhoids/rectal bleeding	☐	☐
Difficulty in breathing/shortness of breath	☐	☐	Emotional/Psychiatric illness	☐	☐
Asthma	☐	☐	Hearing problems	☐	☐
Emphysema	☐	☐	Anemia or blood disorder	☐	☐
Tuberculosis	☐	☐	Foot Problems	☐	☐

Condition cont…	Yes	No	Condition	Yes	No
Eczema, skin problems, hives	☐	☐	Eye problems (other than needing glasses)	☐	☐
Kidney or bladder trouble	☐	☐	Other Chronic Pain______________________		

Other: ____

WELLBEING QUESTIONS:

1. How would you describe your sense of belonging to your community? (Sense of belonging is feeling like you are a part of something, connected and accepted)
   ☐ Very Weak ☐ Somewhat Weak ☐ Somewhat Strong ☐ Very Strong

2. In general, would you say your overall physical health is:
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

3. In general, would you say your overall mental health is:
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

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