

Can we contact you at home? Yes No
 Can we leave a message if necessary? Yes No
 Can we use your preferred name when we contact you? Yes No

If we cannot contact you, please provide other contact information (e.g.: friend, family, shelter)
 Name: _____

Phone Number: (_____) _____ - _____

Do you give us consent to communicate with this individual about your:
 Appointment Information Yes No
 Personal Health Information (eg. test results) Yes No

Do you have a substitute decision maker/legal guardian?
 No Yes. If so, in what capacity? _____

Substitute decision maker/ legal guardian Name: _____

Phone Number :(_____) _____ - _____

Are you connected to any other organizations that provide support to you? Yes No

If yes, please describe: _____

Do you have a worker/case manager/ trustee? Yes No

If yes, please describe: _____

Do you have a Coordinated Care Plan (CCP)? Yes No

If yes, who is the lead? _____
 If no, are you interested? _____

PAST HEALTH CARE

Where have you been going for health care?
 Walk-in clinic Family practice Sexual health centre Emergency/hospital Other

Past health care provider contact information:
 Name: _____

Address: _____
 # Street City Province Postal code

Phone Number: (_____) _____ - _____

What pharmacy/pharmacies do you use? _____

SOCIO-DEMOGRAPHIC/ SOCIO-ECONOMIC

LANGUAGE

What is your mother tongue?
 English French

Other _____ If your mother tongue is neither French nor English, in which of Canada's official languages are you more comfortable?

Do you require language interpretation?

Yes No

In which languages are you most comfortable speaking to your provider? (check all that apply)

- | | | | |
|------------------------------------|---|--|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Amharic | <input type="checkbox"/> Pashto | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Dari | <input type="checkbox"/> Spanish | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Taishanese/
Toishanese | <input type="checkbox"/> Twi |
| <input type="checkbox"/> Romanian | <input type="checkbox"/> Slovak | <input type="checkbox"/> Bengali | <input type="checkbox"/> Georgian |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Tibetan | <input type="checkbox"/> Hausa | <input type="checkbox"/> Hungarian |
| <input type="checkbox"/> French | <input type="checkbox"/> Arabic | <input type="checkbox"/> Polish | <input type="checkbox"/> Rohingya |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Farsi | <input type="checkbox"/> Swahili | <input type="checkbox"/> Ukrainian |
| <input type="checkbox"/> Karen | <input type="checkbox"/> Nepali | <input type="checkbox"/> Urdu | <input type="checkbox"/> Do Not Know |
| <input type="checkbox"/> Russian | <input type="checkbox"/> Somali | <input type="checkbox"/> Bulgarian | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Tamil | <input type="checkbox"/> Tigrinya | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Another Language (please specify): _____ |
| <input type="checkbox"/> Albanian | <input type="checkbox"/> ASL (American Sign Language) | <input type="checkbox"/> Portuguese | |
| <input type="checkbox"/> Czech | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Turkish | |
| <input type="checkbox"/> Korean | | <input type="checkbox"/> Vietnamese | |
| <input type="checkbox"/> Serbian | | <input type="checkbox"/> Burmese | |
| <input type="checkbox"/> Thai | | | |

In what language would you prefer to read healthcare information? (Select only ONE)

- | | | | |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Korean | <input type="checkbox"/> Urdu | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Braille | <input type="checkbox"/> Russian | <input type="checkbox"/> Arabic | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Czech | <input type="checkbox"/> Turkish |
| <input type="checkbox"/> Karen | <input type="checkbox"/> Ukrainian | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Punjabi | <input type="checkbox"/> Amharic | <input type="checkbox"/> Polish | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Chinese (Traditional) | <input type="checkbox"/> Slovak | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Twi | <input type="checkbox"/> Hindi | <input type="checkbox"/> Tigrinya | |
| <input type="checkbox"/> French | <input type="checkbox"/> Nepali | <input type="checkbox"/> Vietnamese | |
| <input type="checkbox"/> Chinese (Simplified) | <input type="checkbox"/> Serbian | <input type="checkbox"/> Bengali | |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Tamil | <input type="checkbox"/> Dari | |
| | | <input type="checkbox"/> Italian | |

IDENTITY

Were you born in Canada?

Yes Prefer not to answer
 No Do not know

If no, what year did you arrive in Canada? _____ What country were you born in? _____

Do you identify as First Nations, Métis and/or Inuk/Inuit? (Check ALL that apply)

This question is about how you identify yourself (e.g. includes status or non-status)

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Yes, First Nations | <input type="checkbox"/> No | <input type="checkbox"/> <u>Prefer not to answer</u> |
| <input type="checkbox"/> Yes, Inuk/Inuit | <input type="checkbox"/> Do not know | |
| <input type="checkbox"/> Yes, Métis | | |

What is your ethnic or cultural background? *For example: Canadian, Chinese, East Indian, English, Filipino, French, German, Irish, Italian, Jamaican, Jewish, Polish, Portuguese, Scottish, etc.*

Which of the following would best describe your racial or ethnic group?
(Check ALL that apply, for example if you are multi-racial or mixed race)

- Not Applicable (e.g., Identified as Indigenous)
- Do not know
- Prefer not to answer
- White (e.g., European descent)
- Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.)
- Latin American (Hispanic or Latin American descent)
- East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.)
- South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.)
- Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.)
- Middle Eastern, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.)
- Another race/ethnic group (Please specify): _____

What is your religious or spiritual affiliation?

- | | | |
|---|--|--|
| <input type="checkbox"/> Agnosticism | <input type="checkbox"/> Jehovah's Witnesses | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Animism or Shamanism | <input type="checkbox"/> Judaism | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Atheism | <input type="checkbox"/> Native Spirituality | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Baha'i Faith | <input type="checkbox"/> Pagan | <input type="checkbox"/> No religious or spiritual affiliation |
| <input type="checkbox"/> Buddhism | <input type="checkbox"/> Protestant | |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Rastafarianism | |
| <input type="checkbox"/> Christian Orthodox | <input type="checkbox"/> Roman Catholic | |
| <input type="checkbox"/> Confucianism | <input type="checkbox"/> Sikhism | |
| <input type="checkbox"/> Hinduism | <input type="checkbox"/> Spiritual | |
| <input type="checkbox"/> Islam | <input type="checkbox"/> Unitarianism | |
| <input type="checkbox"/> Jainism | <input type="checkbox"/> Zoroastrianism | |

What is your citizenship status?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Canadian Citizen | <input type="checkbox"/> Refugee Claimant | <input type="checkbox"/> Visitor Visa |
| <input type="checkbox"/> Landed Immigrant | <input type="checkbox"/> Sponsored Refugee | <input type="checkbox"/> Work Visa |
| <input type="checkbox"/> No Status | <input type="checkbox"/> Student Visa | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Permanent Resident | | |

GENDER/ORIENTATION

What was your sex assigned at birth? (Check one one)

- | | | |
|---------------------------------|---|--------------------------------|
| <input type="checkbox"/> Female | <input type="checkbox"/> Intersex | <input type="checkbox"/> Other |
| <input type="checkbox"/> Male | <input type="checkbox"/> Prefer not to answer | _____ |

What is your current gender identity: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Man | <input type="checkbox"/> Two-spirit | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Woman | <input type="checkbox"/> Trans Female | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Questioning/Unsure | <input type="checkbox"/> Trans Male | |
| <input type="checkbox"/> Genderfluid/Genderqueer | <input type="checkbox"/> Another gender identity | |

What is your sexual orientation?

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Asexual | <input type="checkbox"/> Queer | <input type="checkbox"/> Other |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Straight/Heterosexual | _____ |
| <input type="checkbox"/> Bisexual | (male/female) | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Demisexual | <input type="checkbox"/> Same-gender loving | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Pansexual | <input type="checkbox"/> Questioning or unsure | |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Two Spirit | |

EDUCATION/INCOME

What is your current level of education?

- No formal schooling
- Grade School (*grade 1-8*)
- Some high school, but did not graduate
- High School or High school equivalency certificate (*grade 9-12*)
- Completed Registered Apprenticeship or other trades certificate or diploma
- College, CEGEP, or other non-university certificate or diploma (*or ongoing*)
- Undergraduate degree or some university
- Postgraduate degree or professional designation (e.g. Master's, PhD.MD)
- Do not know
- Prefer not to answer

Are you currently employed?

- Yes
- No
- Prefer not to answer
- Do not know

Are you currently looking for work?

- Yes
- No
- Prefer not to answer
- Do not know

Is your main job temporary or part-time?

- Yes
- No
- Prefer not to answer
- Do not know

In the past 12 months, did your income change from month to month?

- Yes
- No
- Prefer not to answer
- Do not know

What was your total family income before taxes last year?

Yearly income before tax

- \$0 - \$19, 999
- \$20, 000 - \$39, 999
- \$40, 000 - \$59, 999
- \$60, 000 - \$79, 999
- \$80, 000 - \$119, 999
- \$120, 000 - \$149, 999
- \$150, 000 or more
- Do not know
- Prefer not to answer

Per Month

- \$0 - \$1,667
- \$1,668 - \$3,333
- \$3,334 - \$4,999
- \$5,000 - \$6,667
- \$6,668 - \$9,999
- \$10,000 - \$12,499
- \$12,500 or more

Per Hour

- \$0 \$10.25/hr
- \$10.26 - \$20.50/hr
- \$20.51 - \$30.77/hr
- \$30.78 - \$38.46/hr
- \$38.47 - \$61.54/hr
- \$61.55 - \$76.92/hr
- \$76.92 and up/hr

How many people are supported by this income? (including yourself) _____ Number of persons

- Prefer not to answer
- Do not know

Do you feel that your current employment could be negatively affected if you raise concerns about work? (*eg. health, safety, rights*)

- Yes
- No
- Not applicable
- Prefer not to answer
- Do not know

Who do you live with? (*Check all that apply*)

- | | | |
|---|---|--|
| <input type="checkbox"/> Parent(s) or Guardian(s) | <input type="checkbox"/> Other family | <input type="checkbox"/> Paid caregiver or attendant |
| <input type="checkbox"/> Siblings | <input type="checkbox"/> Child(ren) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alone | <input type="checkbox"/> Friends or roommates | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Spouse or partner | <input type="checkbox"/> Grandparent(s) | |
| | <input type="checkbox"/> Do not know | |

Describe your housing situation:

- No problems
- Adequate (minor concerns – eg. drafty windows, conflict with neighbours or other tenants)
- Occasional Problems (eg. issues with physical features of the residence and/or social features such as landlord, other tenants, neighbours)
- Inadequate (eg. issues with physical and/or social features which create ongoing concerns/stress)
- Highly Inadequate (eg. urgent concerns exist over safety, imminent eviction, homelessness)
- Other

Please explain: _____

In the past 12 months, was there a time you were not able to pay the mortgage or rent on time?

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> I did not have to pay rent or mortgage | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> No | | <input type="checkbox"/> Prefer not to answer |

BASIC NEEDS

Do you currently have difficulty paying for basic needs?

- | | | |
|------------------------------|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> I do not have to pay for basic needs | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> No | | <input type="checkbox"/> Prefer not to answer |

Please respond to the following statements:

“Within the past 12 months, we worried whether our food would run out before we could buy or get more”

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Often true | <input type="checkbox"/> Never true | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Sometimes true | <input type="checkbox"/> Do not know | |

“Within the past 12 months, the food we bought just didn’t last and we could not buy or get more”

Often true

- | | |
|---|---|
| <input type="checkbox"/> Sometimes true | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Never true | <input type="checkbox"/> Prefer not to answer |

In the past 12 months, were you unable to get medicine or medical supplies, or did you do anything to make them last longer because of the cost? (*check all that apply*)

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> supplies |
| <input type="checkbox"/> No | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> I did not have to get medicine or medical | <input type="checkbox"/> Prefer not to answer |

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (*Check all that apply*)

- | | |
|--|--|
| <input type="checkbox"/> Yes it has kept me from medical appointments or getting medicines | |
| <input type="checkbox"/> Yes it has kept me from non-medical meetings, appointments, work or getting things I need | |
| <input type="checkbox"/> Not Applicable, I did not need transportation for these activities in the past 12 months | |
| <input type="checkbox"/> No | <input type="checkbox"/> Do not know <input type="checkbox"/> Prefer not to answer |

Do you currently have consistent access to a phone or the internet?

- Both
- Internet only
- Do not know
- Phone Only
- Neither
- Prefer not to answer

In the past 12 months, did you miss making a payment on any utility bills because of cost?
(e.g. electric, gas/oil, water)

- Yes
- Do not know
- No
- Prefer not to answer
- I do not have to pay utility bills

TRANSPORTATION

How will you get to your appointments? _____

Do you experience any difficulties in transportation? _____

LEGAL CONCERNS

What is your current Legal Status?

- No Problem
- Probation
- Incarcerated
- Awaiting trial or sentencing
- Parole
- Other
- Unknown

Please explain: _____

COMMUNITY CONNECTIONS

Are you interested in finding ways to connect with new people and activities in the community?

- Yes
- No

If yes, what type of activities do you enjoy?

CLIENT ACKNOWLEDGEMENT

The above is accurate to the best of my knowledge.

Client Signature

Date: _____

Signature of Quest CHC Provider who reviewed Client Intake

Date: _____

I reviewed:

Quest CHC Client Rights/Responsibilities was reviewed with client/guardian?

- Yes
- No

Statement of Personal Health Information Practices was reviewed with client/guardian?

- Yes
- No

Consent to the Collection, Use & Disclosure of Personal Health Information was reviewed/signed by client/guardian?

- Yes
- No

Consent to Electronic Communication was reviewed/signed by client/guardian?

- Yes
- No