CENTRE DE SANTÉ COMMUNAUTAIRE DE NIPISSING OUEST
WEST NIPISSING COMMUNITY HEALTH CENTRE

P.O.BOX / C.P. 6308 - 68, RUE MICHAUD ST.
STURGEON FALLS, ON - P2B 1B8
TEL/TÉL 705-753-0151 - FAX/TÉLÉC 705-753-5387



**COMMUNITY HEALTH**
***Registration Form***
*PROGRAMMING - ADULT*

# REGISTRATION FORM

☐ I would like to register for the following activity: _____

☐ I am also interested in other activities such as: _____

_____

**WNCHC offers a variety of community programs. To register for one or more programs, please fill out this registration form. This information is kept confidential, and allows us to keep up to date information on our clients, as well as measure our impact on their wellbeing, and the wellbeing of our community.**

Send it by fax at 705-753-5387 or by mail to : 68 Michaud Street, P.O.Box 6308, Sturgeon Falls, ON P2B 1B8

## PERSONAL INFORMATION - MANDATORY SECTION
**Please enter your name as it appears on your Health Card.**

| | | | |
|---|---|---|---|
| **Last Name:** | | **First name:** | |
| ☐ Male ☐ Female ☐ Other | | **Date of Birth:** | YYYY/MM/DD |
| **Telephone:** home | | **Cell** or Other: | |
| **Address:** | | **E-mail:** | |
| **Town:** | | **Postal Code:** | |

*****CONTACT PERSON OR PERSON TO CALL IN CASE OF EMERGENCY*****

Name: Relationship: Tel:

The West Nipissing Community Health Centre (WNCHC) reserves the right to refuse any registration, if it finds that the refusal is in the interest of the individual and the WNCHC.

I agree to participate in the activities of the WNCHC. I agree to release employees and the agents of the WNCHC from any liability, prosecution or claim for loss, damage or injury related to this activity.

Signature of client: _____ Date: _____

Name:

# Sociodemographic information - mandatory

**Religion:**

**Spoken language:**

☐ French ☐ English ☐ Other

**Language of origin:**

**Education (highest level)**

☐ Primary ☐ Secondary ☐ College ☐ University

☐ Other: _____ ☐ Do not know ☐ Do not want to answer

Are you a registered client of the primary care team at the West Nipissing Community Health Centre?

☐ Yes ☐ No

**Ethnicity**

☐ White ☐ Asian ☐ Hispanic ☐ Jewish ☐ First Nation / Inuit / Metis

☐ African ☐ Arab ☐ East Indian ☐ Caribbean ☐ Other: _____

**Citizenship**

☐ Canadian citizen ☐ Refugee ☐ Landed Immigrant ☐ North American Indian

In what country were you born? _____

**Marital Status**

☐ Single ☐ Married ☐ Divorced ☐ Common law ☐ Widow

☐ Other: _____

**Combined annual household income ($/year)**

☐ $0-14,999 ☐ $25,000-29,000 ☐ $40,000-59,999 ☐ Do not know

☐ $15,000-19,999 ☐ $30,000-34,999 ☐ Over $60,000 ☐ Do not want to answer

☐ $20,000-24,999 ☐ $35,000-39,999 Number of people supported by income: _____

**Current household composition**

☐ Mother, father, child(ren) ☐ Single parent family (mother head) ☐ Other _____

☐ Couple without child ☐ Single parent family (father head) ☐ Do not know

☐ Grandparent(s) with granchild(ren) ☐ Same sex couple ☐ Do not want to answer

☐ Extended family ☐ Unrelated housemate

☐ Sole member ☐ Siblings

Name:

## PAR-Q and You

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their health care provider before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your health care provider before you start. If you are over 69 years of age, and you are not used to being very active, check with your health care provider.

**Please answer "YES" or "NO" to the following questions:**

1. Has your health care provider ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? ☐ **YES** ☐ **NO**
2. Do you feel pain in your chest when you do physical activity? ☐ **YES** ☐ **NO**
3. In the past month, have you had chest pain when you were not doing physical activity? ☐ **YES** ☐ **NO**
4. Do you lose your balance because of dizziness or do you ever lose consciousness? ☐ **YES** ☐ **NO**
5. Do you have a bone or joint problem (for example, back knee or hip) that could be made worse by a change in your physical activity? ☐ **YES** ☐ **NO**
6. Is your health care provider currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? ☐ **YES** ☐ **NO**
7. Do you know of any other reason why you should not do physical activity? ☐ **YES** ☐ **NO**

**** IF YOU ANSWERED YES TO ONE OR MORE OF THE ABOVE QUESTIONS****
Talk with your health care provider prior to starting any new physical activity.

Your Doctor or Nurse Practitioner is aware of your participation in these physical activities ☐ **YES** ☐ **NO**

**IF YOU HAVE ANY MEDICAL CONDITIONS, YOU ARE RESPONSIBLE TO ADVISE THE INSTRUCTOR AND HAVE ALL MEDICATIONS WITH YOU (ALLERGIES, DIABETES...)**

Name: _____

## CONSENT TO THE USE OF PHOTOS

On occasion, photos are taken during certain activities. These photos are kept at the West Nipissing Community Health Centre and may be used for advertising purposes.
Do you accept that photos be taken?

☐ **YES** ☐ **NO**

I authorize the West Nipissing Community Health Centre to publish the photos and my name in the media.

Signature of client: _____ Date: _____

## CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION TO THE CLIENT.

The West Nipissing Community Health Centre (WNCHC) recognizes the importance of protecting your personal information and undertakes to collect, use and disclose your personal information in a fair and lawful manner by integrating best practices for the protection of the personal information, including information entrusted to a third party.

The WNCHC collects, uses and discloses information in order to:

*Provide and manage care services for safe primary health care;
*Establish and provide ongoing services and effective health care;
*Communicate with other service providers (with your approval)
*Evaluate and plan your health needs;
*Establish and maintain communication with you:
*Conduct research to improve the quality of health services and / or use the data collected for specific research;
*Meet all legal and regulatory requirements of the law.

**Your signature and date indicate that you have read this document and that you agree with the principles as stated.**

Signature of client: _____ Date: _____