

Client Registration Form



Given Name		Last Name	
Preferred name (if different)			
Date of Birth	□□ / □□ / □□□□ (dd/mm/yyyy)		
Street Address			
Town / Suburb	State	NSW	Postcode 2795
Medicare No:	□□□□ □□□□ □□	Person No:	Expiry Date:
Benefit Card No:		Expiry Date:	
Email address:			
Add me to the CWWHC newsletter email list (usually once per term) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Telephone	Mobile		
	Other	This is my: <input type="checkbox"/> Home <input type="checkbox"/> Work number	
Can we contact you at the above address, number or email? <input type="checkbox"/> Yes <input type="checkbox"/> No (please specify)			
Emergency Contact	Name:	Phone:	
Their relationship to you?			
In which country were you born?	<input type="checkbox"/> Australia	<input type="checkbox"/> Other (please specify)
What country have you lived in for most of your life?	<input type="checkbox"/> Australia	<input type="checkbox"/> Other (please specify)
Are you Aboriginal / Torres Strait Islander?	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> No
What is your cultural background?	<input type="checkbox"/> Australian	<input type="checkbox"/> Other (please specify)
What language do you prefer to speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other (please specify)
Do you need an interpreter?	<input type="checkbox"/> No <input type="checkbox"/> Yes → If "Yes", for what language?		
What is your primary source of income?	<input type="checkbox"/> Pension/Benefit/Student <input type="checkbox"/> Employed <input type="checkbox"/> Sole Trader <input type="checkbox"/> No Income <input type="checkbox"/> Other		
If "Employed", on what basis?	<input type="checkbox"/> Casual <input type="checkbox"/> Part time <input type="checkbox"/> Full time		
Are you	<input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender <input type="checkbox"/> Intersex <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other		
Are you	<input type="checkbox"/> Heterosexual (Straight) <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other		
Do you have disability or suffer from a long-term / chronic health problem? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<i>If "Yes", what kind of disability or health problem?</i>			
Are you a Carer?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who are you caring for? <input type="checkbox"/> Child <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Parent <input type="checkbox"/> Other Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other:	
CWWHC is a Work Development Order Sponsor. Do you have any outstanding fines?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have an NDIS Plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a Visa?	<input type="checkbox"/> No <input type="checkbox"/> Yes Visa type: (please specify)		
Signature			
How did you hear about our Centre?	<input type="checkbox"/> Social Media <input type="checkbox"/> Website / Google <input type="checkbox"/> Centre Flyer / Pamphlet	<input type="checkbox"/> Professional / Organisation <input type="checkbox"/> Newspaper / Magazine / Radio <input type="checkbox"/> Friend / Associate / Relative	<input type="checkbox"/> Walk by <input type="checkbox"/> Other