Registration for ALS Canada

Registration Date:	
What is your diagnosis?	□ ALS □ PBP □ PLS □ HSP □ Kennedy's Disease □ PMA
Client Name:	
Title:	□ Mr. □ Mrs. □ Ms. □ Dr. □ Other: _____
Preferred Name:	
Date of Birth:	
Gender:	□ Male □ Female □ Non-Binary □ I prefer not to say □ Other: _____
Which of the following best describes you?	□ Black □ Asian □ First Nations, Inuit, or Metis □ Latino □ Middle Eastern □ White □ A race not listed □ I prefer not to say □ Other: _____
Relationship Status:	□ Single □ Common Law □ Married □ Separated □ Divorced □ Widowed (The definition of a common-law partner should be read as "an individual who is (ordinarily) cohabiting." After the one-year period of cohabitation has been established, the partners may live apart for periods of time while still maintaining a common-law relationship)
Email:	
Cell #:	
Home #:	
How would you like us to communicate with you?	□ Email □ Home Phone □ Work Phone □ Cell Phone □ Text □ Other: _____ **(Please note that some communications will be sent by email)**
Primary language spoken at home	■ English □ French □ Other: _____
Do you live alone?	■ Yes □ No
Client Address:	
Is the above address:	□ House or Apartment □ Hospital □ Long-term Care □ Other: _____
Please indicate who your preferred contact is:	□ Self □ Alternative Contact

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(1) Alternative Contact Name:	
(1) Alternative Contact Relationship:	□ Spouse □ Parent □ Son □ Daughter □ Other: _____
(1) Alternative Contact Email:	
(1) Alternative Contact Home or Cell #	
(1) Alternative Contact Address: □ Same as above	
(2) Alternative Contact Name:	
(2) Alternative Contact Email:	
(2) Alternative Contact Phone:	
Have you served in the Military or are you a veteran?	□ Yes □ No
Number of children under the age of 18	
Child 1: Name & DOB	
Child 2: Name & DOB	
Child 3: Name & DOB	
Child 4: Name & DOB	
Date of your diagnosis:	
Who is your neurologist?	
Have you been to any ALS Clinic?	□ Yes □ No
If yes, which one?	□ ALS Clinic – McMaster University Medical Care, Hamilton Health Services □ Kingston – Providence Care Hospital □ Motor Neuron Disease Clinic – London Health Sciences □ The Ottawa Hospital Rehab Centre □ ALS Clinic – Sunnybrook Health Sciences Centre □ Other: _____
Do you or your spouse have Extended Health Benefits?	□ Yes □ No **If yes, name of Health Benefits Provider:** _____
Client Status of Employment:	□ Current – Full-Time □ Current – Part-Time □ Disability □ Retired □ Medical Leave □ Unemployed □ Other: _____
Client Occupation:	

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	Client Income is collected for the sole purpose of analytics. Programs and services are provided to people of all income levels.
Client Income:	
Is there any additional information you would like to provide to ALS at this time?	
	By selecting the boxex below, you agree to the following:
	☐ 1. I confirm that everything on this form is true. ☐ 2. I acknowledge that ALS will not provide services to individuals who use abusive language ☐ 3. Data use and privacy - privacy policy link, use of data for communication to provides services/programs and for information related to fundraising events + we will use your data to contact other health care professionals on your behalf
Person completing this form email:	
Contact phone number of person completing this form:	
Signature of person completing this form:	