WELCOME TO OUR HEALTH CLINIC

KINGSTON INTEGRATED HEALTHCARE INC.

We're glad you're here!

THANK YOU for taking time to explore our clinic and your healthcare options. We're passionate about our work and look forward to working with you over the coming months!

HEALTH CANADA estimates that more than half of all Canadians use some form of integrative medicine. Integrative medicine combines the strengths of multiple medical perspectives and perceives the person as a whole, integrated unit.

People request our services for a variety of reasons:

- Disease management, prevention, or education
- Chronic pain or disability
- Drug or surgery alternatives
- Desire to improve quality of life
- Physical, mental, or emotional, concerns

We help the body restore optimal function by addressing underlying causes of illness for effective, long-lasting results.

Current information about our services and workshops is offered in our e-newsletter which you may sign up for on our website. Our team members share unique health articles here in what we hope you'll find to be a fun and educational resource worth sharing.

Please take your time when completing the following new patient forms. They are an important initial step toward defining your healthcare needs and achieving your health goals.

We're a team of 10 health professionals offering expertise in complementary, alternative, and integrative medicine.

- Naturopathic Medicine
- Massage Therapy
- Osteopathy
- Acupuncture
- Physiotherapy
- Reiki and Bioenergy
- Holistic Nutrition
- Clinical Pharmacy
- Homeopathy
- Medical testing
- Community Workshops

With your permission, your KIHC health practitioner may consult other clinic professionals or refer you for co-care.

All of our practitioners offer complimentary 15 minute introductory appointments to help you find the right professionals for your personal healthcare team.

Jianmin (Jamie) Xu R.Ac.
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc • www.kihc.ca

GENERAL INTAKE FORM

Every detail you provide will help you achieve your health goals and will remain confidential. Please bring this completed form to your first appointment, along with any relevant health reports.

Name: ______________________________ Date: ________________

Date of birth (dd/mm/yy): ______________ Age: ______ Gender: ____________

Address: ____

____

Home Tel: __________ Work Tel: __________ Email address: ______________

What is the best way for us to contact you? ______________________________

May we leave telephone messages at home or work? ________________________

Would you like to receive our clinic email newsletter? ______________________

How did you hear about this health practice? ____________________________

Emergency contact information:

Name: ________________ Relationship: ____________ Tel: ____________

Please list all other healthcare practitioners you are seeing:

1. ________________	2. ________________	3. ________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
( ) ____________	( ) ____________	( ) ____________

Please list your primary health concerns, in order of importance:

1. ________________________________ Date of onset: ____________
2. ________________________________ Date of onset: ____________
3. ________________________________ Date of onset: ____________
4. ________________________________ Date of onset: ____________

Jianmin (Jamie) Xu R.Ac.
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

MEDICAL HISTORY

Please list any hospitalizations, surgeries, traumas (including emotional traumas) or major illnesses:

1. ________________________ Date started: ____________ Date Resolved: ____________
2. ________________________ Date started: ____________ Date Resolved: ____________
3. ________________________ Date started: ____________ Date Resolved: ____________
4. ________________________ Date started: ____________ Date Resolved: ____________

Please list any **medications, supplements** or **vitamins** you are taking, including antacids, pain medications, and laxatives:

1. ______________________________ Date started: ____________ Dose: ____________
2. ______________________________ Date started: ____________ Dose: ____________
3. ______________________________ Date started: ____________ Dose: ____________
4. ______________________________ Date started: ____________ Dose: ____________
5. ______________________________ Date started: ____________ Dose: ____________

Approximately how many times have you been treated with antibiotics? ________________

Please list any allergies, sensitivities, or adverse reactions (e.g. to medications, immunizations, food, chemicals, pets): ____

____

EMOTIONAL HEALTH

On a scale of 1 (low) to 10 (high), please rate your overall level of stress: ________________

On a scale of 1 (low) to 10 (high), please rate your overall energy level: ________________

On a scale of 1 (low) to 10 (high), please rate how happy you are generally: ________________

How would you describe the emotional climate of your home? ________________________

____

Do you feel that your home is a safe place? ________________________________

Do you have any concerns regarding your emotional or mental health (please describe)? ________

____

____

____

541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc • www.kihc.ca

LIFESTYLE

How often do you consume the following:

Alcohol: ______________________________ Recreational Drugs: __________________________

Caffeine: _________________Water: ________________ Tobacco: __________________________

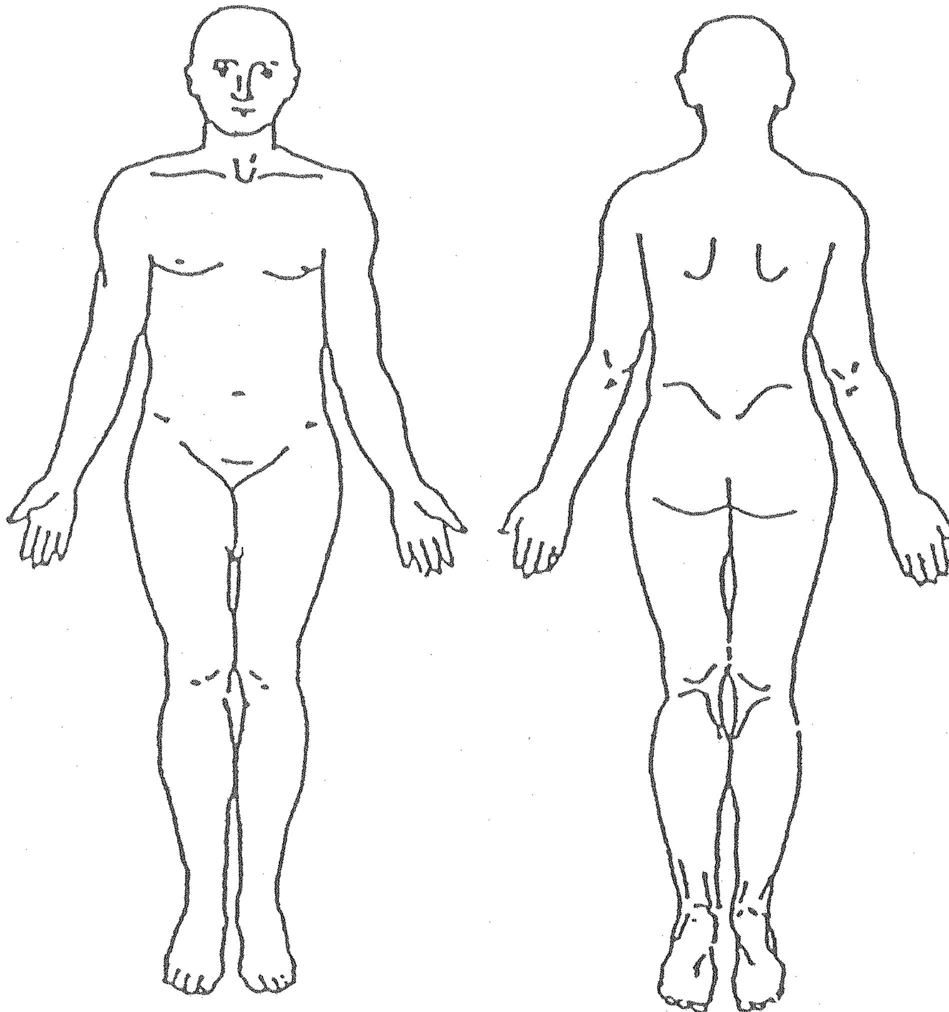
Please describe what forms of exercise you participate in, and how often:

____

What is your occupation? ____

Please list some of your hobbies: ____

Please draw on the diagram where you have symptoms, and rate the symptom from 1 (very mild), to 10 (severe):



Jianmin (Jamie) Xu R.Ac.
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

REVIEW OF SYSTEMS CONDITIONS

Please mark "C" for current conditions and "P" for any conditions you've had in the past:

CONDITION	C	P		C	P
Skin					
Rash, eczema, hives			Excessive sweating/ Night sweats		
Acne			Nail or hair changes		
Colour change or change in a mole			Boils		
Warts, lipomas, or other masses			Excessive dry skin		
Head, Nose & Sinus					
Headache or migraine			Hair loss		
Head injury			Dandruff		
Nose bleeds			Sinus infections		
Nose stuffiness			Loss of smell		
Ears					
Impaired hearing or ringing			Ear pain or infections		
Eyes					
Eye pain			Glaucoma or Cataracts		
Tearing, dryness, itching, redness			Spots or "floaters"		
Discharge			Double or blurred vision		
Mouth, Throat & Neck					
Frequent sore throat or throat dryness			Hoarseness		
Sore tongue or mouth sores			Dental cavities or teeth problems		
Cold sores			TMJ or jaw pain		
Gums bleeding or receding			Loss of taste		
Swollen lymph nodes in neck			Thyroid problems		
Musculoskeletal					
Joint pain or stiffness; Arthritis			Muscle soreness		
Neck, back, or foot pain			Muscle spasms or cramps		
Broken bones			Muscle weakness		
Respiratory					
Prolonged Cough or Phlegm			Difficulty or pain breathing		
Asthma, emphysema			Shortness of breath at night		
Frequent colds, bronchitis, or pneumonia			Tuberculosis		
Cardiovascular					
Heart disease			High cholesterol		
High or low blood pressure			Sensation of blood rushing in ears		
Murmurs			Palpitations (can feel heart beating)		
Chest pain			Rapid, slow, or irregular heart rate		
Peripheral Vascular, Hematological & Lymphatic					
Deep leg pain			Anemia		
Cold or numb hands/feet			Easy bleeding or bruising		
Varicose veins or spider veins			Lymph node swelling		
Swelling ankles			Swelling wrists		

Jianmin (Jamie) Xu R.Ac.
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

REVIEW OF SYSTEMS CONDITIONS

Please mark "C" for current conditions and "P" for any conditions you've had in the past:

CONDITION	C	P		C	P
Gastrointestinal					
Heartburn or Reflux			Diarrhea or loose stool		
Ulcer			Constipation		
Indigestion, bloating after eating			Blood in stool or rectal bleeding		
Sensation of heaviness after eating			Black or clay (grey) coloured stool		
Belching or passing gas			Floating stool		
Recurrent nausea or vomiting			Undigested food in stool		
Change in thirst or appetite			Rectal or anal itching		
Excessive thirst or appetite			Change in bowel habits		
Abdominal pain			Liver disease, such as hepatitis		
Hemorrhoids or Hernia			Gall Bladder stones and/or disease		
Urinary System					
Pain during urination			Frequent infections		
Increased frequency or excessive urination			Kidney or bladder stones		
Hesitancy or urgent urination			Dark coloured urine		
Neurologic					
Fainting/ Loss of consciousness			Loss of memory or confusion		
Dizziness/ Loss of balance			Speech or swallowing difficulty		
Seizures/Convulsions			Numbness or tingling		
Paralysis			Involuntary movement		
Mental & Emotional Health					
Depression, anxiety, or nervousness			Difficulty concentrating		
Episodes of extreme energy or mood swings			Phobias		
Female System					
Breast pain, tenderness, or lumps			Menstrual cycle pain or other difficulty		
Breast discharge			Menopausal symptoms		
Vaginal infection or discharge			Syphilis, chlamydia, or gonorrhea		
Male System					
Prostate problems			Testicular lumps, sores, or pain		
Syphilis, chlamydia, or gonorrhea			Penile sores or discharge		
General					
Unexplained or excessive fatigue			Allergies (environmental and food)		
Unintentional weight loss or gain			Insomnia or sleep difficulties		
Blood sugar problems (high or low)			Dizziness or vertigo		

Jianmin (Jamie) Xu R.Ac.
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

FAMILY HISTORY

Please indicate whether the following health conditions **pertain to any of your family members:**

Heart concerns (e.g. high blood pressure): ______________________________

Lung disorders (e.g. asthma): ______________________________

Nervous system disorders (e.g. seizures): ______________________________

Digestion concerns (e.g. Crohn's disease): ______________________________

Allergies (moderate/severe): ______________ Diabetes: ______________

Skin concerns: ______________ Cancer: ______________

Autoimmune disease: ______________ Mental illness (e.g. depression): ______________

Difficulties with drugs and/or alcohol: ______________________________

Other: ______________________________

EXAM HISTORY

Please indicate when you most recently (if ever) had the following tests/procedures performed:

CT,MRI, or ultrasound: ______________

Hearing test: ______________

X-ray: ______________

PAP smear or gynacological exam: ______________

Blood or urine test: ______________

Prostate exam: ______________

ECG: ______________

Eye exam: ______________

Tuberculin (TB) test: ______________

Full physical exam: ______________

Is there anything else you would like to include on this form? ______________________________

____

____

____

Thank you.

Jianmin (Jamie) Xu R.Ac.
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

INFORMED CONSENT FOR TREATMENT

Using ancient scientific principles, acupuncture treats illness by bringing a person's body into harmony and balance, by stimulating acupoints along the meridians of the body. The techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: the electrical stimulation of needles, acupressure, cupping, moxibustion, and guasha.

Your first appointment lasts approximately 60-90 minutes, includes a health assessment and treatment, and costs $120. Follow-up treatments generally last 45 to 60 minutes and cost $75 to $90. OHIP does *not* cover the fees of the treatment, however many extended healthcare insurance providers do. Services provided by Registered Acupuncturists are exempt from HST.

STATEMENT OF ACKNOWLEDGEMENT

I, ________________________________, as a patient of Jianmin Xu, understand that the form of health care is based on Traditional Chinese Medicine principles and practices. I will inform her of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements, because safe care requires that I truthfully and completely disclose this information. I will also inform Jianmin if I am pregnant or breastfeeding.

I understand that though acupuncture treatments are generally safe and gentle, there may be health risks and symptoms associated with some acupuncture treatments which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration, and the possibility of other unforeseen risks.

I understand that only disposable, sterilized needles will be used for my treatment and that these needles will be disposed of following the treatment.

I will inform Jianmin if I suffer from any type of bleeding disorder, if I have a pacemaker, and if I may be carrying any infectious agent, including but not limited to HIV, Tuberculosis, or Hepatitis.

I understand that there are no guarantees for the results of my treatments. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.

I acknowledge that I have had the opportunity to discuss my proposed treatment with Jianmin and that she has answered all of my questions to the best of her ability. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment, including a **50% late cancellation fee if providing less than 24 hours' notice for cancelling my appointments.** I am aware that I am always at liberty to seek or continue care from another healthcare provider.

____________________	____________________	____________________
SIGNATURE	DATE	WITNESS

Jianmin (Jamie) Xu R.Ac.
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Your health privacy is a primary concern and the personal health information you disclose to Jianmin Xu during your appointments will be handled in accordance with current privacy legislation. Personal health information includes identifiable information such as age, gender, family status, and health history.

Jianmin Xu, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize Jianmin Xu, employees, and health practitioners of 541 Palace Road to collect, use, and disclose my personal health information as outlined above.

______________________________	______________________________
NAME	DATE
______________________________	______________________________
SIGNATURE	WITNESS