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
- Medication Therapy Management
- Holistic Nutrition
- Reiki and Bioenergy
- 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.

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ADULT INTAKE FORM

Please bring this completed form to your first appointment along with any relevant health reports. The details you provide will remain confidential.

Name: _____ Date: _____

Date of birth (dd/mm/yy): _____ Age: _____ Gender: _____

Address: _____

_____ Postal Code: _____

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 holistic nutrition practice? _____

Emergency contact information:

Name: _____ Relationship: _____ Tel: _____

Please list all other practitioners on your healthcare team (e.g. medical doctor, dentist, etc.):

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

( ) _____ ( ) _____ ( ) _____

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

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

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MEDICAL HISTORY

Have you been diagnosed with a disease, syndrome, or other ailment? _____

_____

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: _____

Please indicate if any of these experiences still negatively influence your life: _____

_____

Please list all **pharmaceuticals** you are taking, including antacids, pain medications, and laxatives:

1. _____ Date started: _____ Dose: _____ Time of day: _____
2. _____ Date started: _____ Dose: _____ Time of day: _____
3. _____ Date started: _____ Dose: _____ Time of day: _____

Please list all **supplements or vitamins** you are taking:

1. _____ Date started: _____ Dose: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____

Please share your antibiotic history and the reason for each occurrence:

1. _____ Date started: _____ Finished: _____
2. _____ Date started: _____ Finished: _____
3. _____ Date started: _____ Finished: _____

Please share your history of birth control use (e.g. birth control pill, IUD, nuva-ring):

1. _____ Date started: _____ Finished: _____
2. _____ Date started: _____ Finished: _____

Have you ever used NSAIDs (e.g. Advil, Aleve, Aspirin) for prolonged periods of time? Yes/No

Have you ever used Tylenol (Acetominophen) for prolonged periods of time? Yes/No

Have you ever used ant-acids or heartburn medication (e.g. Zantac, Tums), regularly? Yes/No

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Birth History:
Please check all that apply to you**:**
O Born via C-section O Born vaginally O Primarily breastfed O Primarily bottle-fed
O Complications: _____

Childhood History:
Please check all that apply to you**:**
O ADHD or ADD O Food allergies/sensitivities O Frequent ear infections O Colic
O Tonsil removal O Frequent bed wetting O Skin concerns O Trauma
O Other: _____

Describe your diet as a child and young adult: _____

_____

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

Have you ever experienced fungal infections such as jock itch, yeast infection, or athlete's foot? _____

How often do you have a bowel movement?_____

Do you have any concerns about your stool (e.g. undigested food, loose, difficult to pass)? _____

_____

NUTRITION

Have you ever had an appointment with a Dietician or Nutritionist?_____

What is your philosophy around food? _____

_____

Do you have a history of dieting, or eating disorders? Please describe: _____

_____

Do you have any negative perceptions or a poor relationship with food? _____

Do you follow a specific diet or have any food restrictions? Describe: _____

_____

How many 8 oz glasses of water do you drink daily? _____

What kind of water do you regularly consume (please circle): filtered/tap/well/bottled/ Spring/ mineral water/ Reverse Osmosis/ distilled/ other: _____

What are your favourite foods? _____

Food dislikes? _____

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Check all factors that apply to your eating habits and current lifestyle:

O Stress eater
O Emotional eater
O Late-night snacker
O Enjoy eating
O Enjoy cooking
O Unhealthy relationship with food
O Confused about food/nutrition
O Prefer restaurant eating
O Speed eater
O Find eating a chore
O Dislike cooking
O Overeat often
O Rely on convenience foods
O Choose fast food often
O Inconsistent eating patterns
O Live alone or eat alone often
O Travel frequently
O Family members have different tastes
O Time constraints
O Do not plan meals/menus
O Life to follow routine
O Like to go with the flow
O Don't know how to cook
O Skip meals
O Other:_____

How much variety is in your diet? Do you eat the same foods repeatedly? _____

_____

Do you experience symptoms if meals are missed? Please describe: _____

_____

LIFESTYLE

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

_____

How many hours of sleep do you get per night? _____Do you wake feeling rested? _____

What is your occupation (if retired, please specify occupational history)? _____

Are you a shift worker? _____

Please list some of your hobbies: _____

Please briefly describe your travel history:_____

_____

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? _____

Have you ever felt sad or depressed for two weeks or more at a time in the past year? Yes No

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

_____

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ENVIRONMENT

How commonly are you exposed to the following at home or work (1= rare; 2=sometimes; 3=often):

O Chemical cleaners: _____
O Wireless internet/EMF: _____
O Tap water: _____
O Processed food: _____
O Non-natural bodycare products:
O Tobacco: _____
O Aluminum cookware: _____
O Non-stick cookware: _____
O Food in plastic containers: ___
O Mould: _____
O Alcohol: _____
O Recreational drugs: _____
O Caffeine: _____
O Other: _____

FAMILY HISTORY

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

Condition	Relative	Age of Onset	Details
Heart problems or stroke (e.g. high blood pressure)			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. Crohn's disease)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Diabetes			
Autoimmune disease (e.g. lupus, rheumatoid arthritis, Crohn's disease)			
Mental illness (e.g. depression)			
Difficulties with drugs and/or alcohol			
Other: (e.g. birth defect, Lyme disease, bleeding disorder)			

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

_____

_____

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REVIEW OF SYSTEMS

Please circle and/or check (√) whether you are currently experiencing the following concerns (C), or if you have experienced them in the past (P):

CONDITION	C	P		C	P
Skin, Hair & Nails					
Rash, eczema, hives			Excessive dry skin or itchy skin		
Acne or rosacea			Fungal infection (e.g. tinnea, toenail)		
Change in a mole			Hair loss, dryness, or dandruff		
Warts, lipomas, cysts, or other masses			Nail splitting, peeling, breaking		
Head, Nose & Sinus					
Recurrent headache or migraine			Post nasal drip, nasal polyps		
Head injury or concussion			Change in sense of smell		
Recurring nose bleeds or nose stuffiness			Tendency to sinus infections		
Ears & Eyes					
Eye condition (e.g. cataracts, glaucoma)			Ear pain or infections		
Eye dryness, itching, tearing or other			Excessive ear wax (cerumen)		
Spots or "floaters"			Impaired hearing or ringing		
Mouth, Throat & Neck					
Frequent sore throat, mouth, or tongue			Gums bleeding (e.g when flossing)		
Canker (mouth) sores or cold sores			Dental cavities, root canals, or implants		
Hoarseness, swallowing or voice problem			TMJ, jaw pain, or teeth grinding		
Chronic cough or throat clearing			Loss of sense of taste		
Musculoskeletal					
Joint pain or stiffness; Arthritis			Muscle soreness, stiffness, or weakness		
Neck or back pain (e.g. herniated disc)			Muscle spasms or cramps		
Osteoporosis or Osteopenia			Foot pain (e.g. plantar fasciitis)		
Respiratory					
Frequent colds, bronchitis, or pneumonia			Difficulty breathing or short of breath		
Asthma, emphysema, or other condition			Prolonged Cough or Phlegm		
Positive test for tuberculosis (TB)			Use of steroid inhalers		
Cardiovascular, Peripheral Vascular, & Hematological					
High or low blood pressure			Swollen ankles or wrists		
Heart murmurs or irregular heart rate			Sensation of blood rushing in ears		
Rapid or slow heart rate			Unusually cold hands or feet		
Palpitations (can feel heart beating)			Varicose veins or deep leg pain		
Anemia			Easy bleeding or bruising		

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CONDITION	C	P		C	P
Gastrointestinal					
Heartburn, reflux, bad breath, burping			Diarrhea or loose stool		
Indigestion, nausea, bloating, or ulcer			Constipation		
Sensation of heaviness after eating			Blood, mucous, or food pieces in stool		
Passing gas, flatulence			Black, grey, or green discoloured stool		
Recurrent abdominal pain or hernia			Frequently floating or greasy stool		
Hemorrhoids, anal fissures, or itching			Intolerant to cabbage, garlic, or eggs		
Gallbladder or liver condition			Intolerant to greasy or fatty foods		
Urinary System					
Urinary pain, frequency, or urgency			Frequent bladder or kidney infections		
Excessive or hesitant urination			Kidney or bladder stones		
Mid-back or flank (side) pain			Dark or discoloured urine		
Mental, Emotional, Neurological					
Depression, anxiety, or nervousness			Difficulty focusing, thinking, or speaking		
Extreme energy or mood fluctuations			Memory loss or confusion		
Female System					
Breast pain, tenderness, lumps, or discharge			Menopausal hot flushes or sweats		
Menstrual cycle longer than 30 days			Recurrent vaginal infection or symptom		
Menstrual cycle shorter than 27 days			Ovarian cysts		
Menstrual pain or heavy bleeding			Use of birth control pills or hormone IUDs		
Mammogram or breast exam in last 3 years			PAP exam in last 3 years		
Male System					
Prostate problems			Testicular lumps, sores, or pain		
Erectile dysfunction			Penile sores or discharge		
Generalized					
Unexplained or excessive fatigue			Allergies (e.g. environmental, food)		
Unintentional weight loss or gain			Chemical sensitivity (e.g. perfume)		
Blood sugar problems (high or low)			Dizziness, vertigo, light-headedness		
Unusual or change in thirst or appetite			Numbness, tingling		
Recurring fever, sweats, or chills			Seizures, tremors, involuntary movement		
Chronic infection (e.g. herpes, hepatitis)			Insomnia, sleep difficulties, or snoring		
Enlarged lymphnodes (e.g. on neck, groin)			Change in libido		
Abnormal blood, lab, or medical test result			Fertility concerns		

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FOOD JOURNAL

Name: _____ Date: _____

Weekday	Breakfast	Snack 1	Lunch	Snack 2	Dinner	Symptoms
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Instructions:	Please record your food intake in as much detail as possible	What food brands are you eating?	Please include what time you are eating.	Include your hydration in the extra white space on the side of the page.	Do you eat while rushed or at peace?	Symptoms can include bloating, headaches, pain, shaky, sluggishness, irritation, etc.

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INFORMED CONSENT FOR TREATMENT

A Registered Holistic Nutritionist (RHN) is a professional trained in creating individualized health plans that include nutritional, lifestyle, supplement, and psycho-spiritual recommendations. Based on their clients' unique biochemistry and health requirements, care plans may include targeted meal plans, guidance for healthy food preparation and consumption, suggestions for addressing lifestyle habits that may interfere with optimal health, and nutritional supplements. A RHN works in partnership with other healthcare providers to ensure that clients receive the most effective care possible.

Your first appointment will generally last 60 minutes and may include a symptoms-based interview, discussion of health needs and goals, and specific recommendations for co-care. Follow-up appointments may range from 30-45 minutes depending on your individual health requirements. The first consultation fee is $85 and does not include the cost of supplement items. OHIP does *not* cover the fees of a RHN, however some extended healthcare insurance providers do. HST is applied to services offered by Registered Holistic Nutritionists.

STATEMENT OF ACKNOWLEDGEMENT

I, _____, as a patient of _____, understand that the form of health care is based on principles and practices characteristic of holistic nutrition. I will inform my practitioner 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 my practitioner if I am pregnant or breastfeeding.

I understand that I am entitled to know about my care plan, including the costs, benefits, risks and potential side-effects. I am entitled to know the consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my care. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I understand that though care plans offered by RHNs are generally safe and gentle, there may be health risks associated with some recommendations, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to foods or supplements, and potential detoxification symptoms. I understand that while some symptoms may resolve quickly, others may take more time to improve or may not improve at all.

I understand that my RHN is **not** able to guarantee results. 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

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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 your Registered Holistic Nutritionist (RHN) 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.

Your RHN, 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 _____, Registered Holistic Nutritionist, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

_____ _____
NAME DATE

_____ _____
SIGNATURE WITNESS