Kingston Integrated healthcare Inc.
541 Palace Road Kingston, ON K7L 4T6
613.547.KIHC ● www.kihc.ca

LIMITLESS LIVING GOALS & TREATMENT QUESTIONNAIRE

Name: _____ Date: _____

Date of birth (dd/mm/yy): _____Age: _____Gender: _____

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

Why did you join the Limitless Living community? _____

_____

Why are you considering additional medical support at KIHC? _____

_____

_____

Please list your top 3 health goals as they relate to your Limitless Living activities:

1. _____
2. _____
3. _____

What top change *specifically* do you wish to see in the coming 4 months?

_____

_____

Please rate the following statements, with 1 (not true) to 5 (very true):

Obstacles preventing me from easily attaining my Limitless Living goals, include:

Body pain (e.g. muscles, joints, old injuries):	1	2	3	4	5
Fatigue (e.g. from insomnia, suboptimal stamina):	1	2	3	4	5
Mental health concerns (e.g. depression, anxiety, low motivation):	1	2	3	4	5
Chronic illness (e.g. neurological or cardiovascular disease):	1	2	3	4	5
Time management challenges (e.g. from a very busy lifestyle):	1	2	3	4	5
Breathing difficulty (e.g. asthma, cardiovascular disease, COPD):	1	2	3	4	5
Inadequate social support system (e.g. family, friends):	1	2	3	4	5
Other: _____	1	2	3	4	5
Other: _____	1	2	3	4	5

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My personal beliefs and preferences regarding health and wellness, include:

Given the right tools, my body has the ability to heal itself:	1	2	3	4	5
I prefer to work with a practitioner who tells me what I need to do:	1	2	3	4	5
My style is to research as much as I can about my health concerns:	1	2	3	4	5
Preventing illness is a priority for me:	1	2	3	4	5
I am hesitant to try non-mainstream healthcare approaches:	1	2	3	4	5
Intuition plays a big role in my health choices:	1	2	3	4	5
I value the healing process just as much as the end goal:	1	2	3	4	5

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

Address your exercise routine:_____ Change your diet: _____

Invest financially in your health: _____ Invest time into your health goals:_____

Rate how familiar you are with each of the following professions in Ontario, from 1 (entirely unfamiliar) to 10 (very familiar):

Naturopathic medicine	1	2	3	4	5	6	7	8	9	10
Osteopathy	1	2	3	4	5	6	7	8	9	10
Physiotherapy	1	2	3	4	5	6	7	8	9	10
Registered Massage Therapy	1	2	3	4	5	6	7	8	9	10
Registered Holistic Nutrition	1	2	3	4	5	6	7	8	9	10
Registered Acupuncture	1	2	3	4	5	6	7	8	9	10
Reiki or Therapeutic Touch	1	2	3	4	5	6	7	8	9	10
Counselling or Psychotherapy	1	2	3	4	5	6	7	8	9	10

Rate how curious or interested you are in experiencing each modality from 1 (uninterested) to 10 (very interested):

Acupuncture:	1	2	3	4	5	6	7	8	9	10
Hands-on treatments such as massage, physio, osteopathy:	1	2	3	4	5	6	7	8	9	10
Consultation-type treatments:	1	2	3	4	5	6	7	8	9	10
Light touch therapies such as reiki or craniosacral:	1	2	3	4	5	6	7	8	9	10
Medical or holistic nutrition:	1	2	3	4	5	6	7	8	9	10
Specialized medical testing:	1	2	3	4	5	6	7	8	9	10
Natural Health Products (e.g. vitamins, botanicals):	1	2	3	4	5	6	7	8	9	10
Mindfulness meditation instruction:	1	2	3	4	5	6	7	8	9	10

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Please list any health conditions and diagnoses not previously mentioned:

1._____ Date of onset: _____

2._____ Date of onset: _____

3._____ Date of onset: _____

4._____ Date of onset: _____

5._____ Date of onset: _____

Please list all **medications and supplements** 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: _____

Is insurance coverage a necessary consideration in your choice of ideal healthcare service? _____
(*Please see our FAQ about insurance coverage, on our website*.)

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

_____

_____

Thank you.

Practitioners' Notes: