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 health professionals offering expertise in complementary, alternative, and integrative medicine.

- Naturopathic Medicine
- Physiotherapy
- Massage Therapy
- Osteopathy
- Acupuncture
- Medication Therapy Management
- Reiki and Bioenergy
- Homeopathic Medicine
- 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.

Kingston Integrated Healthcare
Medication Therapy Management
541 Palace Road Kingston, Ontario K7L 4T6
613.547.5442 • www.kihc.ca

ADULT INTAKE FORM

Please bring this completed form to your first appointment. This information 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 Medication Therapy Management?_____

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

1. _____ 2. _____ 3. _____

_____ _____ _____

( ) _____ ( ) _____ ( ) _____

GENERAL HEALTH

How would you rate your overall health status, from 1 (very poor) to 10 (fantastic): _____

Please list all diagnoses and health conditions:

1._____ Date of onset: _____

2._____ Date of onset: _____

3._____ Date of onset: _____

4._____ Date of onset: _____

Please list any hospitalizations, surgeries, or major illnesses:

1. _____ Date started: _____ Date Resolved: _____

2. _____ Date started: _____ Date Resolved: _____

3. _____ Date started: _____ Date Resolved: _____

4. _____ Date started: _____ Date Resolved: _____

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Medication Experience

What is your general attitude toward taking medication? _____

Please list your goals with your drug therapy:

1. _____
2. _____
3. _____
4. _____

What concerns do you have about your medication? _____

_____

_____

Please list all allergies, drug allergies, and adverse reactions you've experienced: _____

_____

_____

Are you currently pregnant or breastfeeding? _____

Current Medications

Please list all your current medications, including over-the-counter medications, pain medications, antacids, vitamins, and natural health products:

1. _____ Date started: _____
2. _____ Date started: _____
3. _____ Date started: _____
4. _____ Date started: _____
5. _____ Date started: _____
6. _____ Date started: _____

Please list all medications you have taken **in the past**:

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

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For each medication you take, please indicate the following:

	Medication #1	**Medication #2**
Medication name:		
Dose:		
Health condition treated:		
When do you take it?		
Who prescribed it?		
When was it prescribed?		
How effective is it for you?		
Do you have any concerns?		

	Medication #3	**Medication #4**
Medication name:		
Dose:		
Health condition treated:		
When do you take it?		
Who prescribed it?		
When was it prescribed?		
How effective is it for you?		
Do you have any concerns?		

	Medication #5	**Medication #6**
Medication name:		
Dose:		
Health condition treated:		
When do you take it?		
Who prescribed it?		
When was it prescribed?		
How effective is it for you?		
Do you have any concerns?		

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Social Drug Use

How much and how often do you consume the following:

Alcohol: _____ Recreational Drugs: _____

Caffeine: _____Cannabis: _____ Tobacco: _____

Lifestyle

Please list names and ages of all persons currently residing in your home: _____

_____

What is your occupation? _____

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

_____

_____

Do you have any dietary restrictions (for health reasons or otherwise)? _____

_____

Please describe a typical day's diet:

Breakfast: _____
Lunch:_____
Dinner: _____
Snacks: _____
Beverages: _____

Please list some of your hobbies: _____

Please briefly describe your travel history:_____

_____

How many hours of sleep do you get each night on average? Please describe your sleep quality (e.g. snoring, restlessness, fatigue on waking). _____

_____

Mental & Emotional Health

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

_____

_____

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On a scale of 1 (low) to 10 (high), how would you rate your overall **stress** level? _____

On a scale of 1 (low) to 10 (high), how would you rate your overall **energy** level? _____

On a scale of 1 (low) to 10 (high), how **happy** are you generally? _____

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

_____

Do you feel safe at home? _____

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

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. rheumatoid arthritis)			
Mental illness (e.g. depression)			
Difficulties with drugs and/or alcohol			
Other: (e.g. birth defect, bleeding disorder)			

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

_____

Thank you.

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INFORMED CONSENT FOR MEDICATION THERAPY MANAGEMENT

Medication management involves patient-centred care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams. A Pharmacist's role includes:

- Assessing patients and their medication-related needs and identifying actual or potential drug therapy problems;
- Formulating and implementing care plans to prevent and/or resolve drug therapy problems;
- Recommending, adapting or initiating drug therapy where appropriate;
- Monitoring, evaluating and documenting patients' response to therapy, and;
- Collaborating and communicating with other health care providers, in partnership with patients.

Your first Medication Management Therapy consultation will generally last 30 to 45 minutes. Follow-up appointments are generally 15 minutes, but will vary according to your individual health requirements. The first consultation fee is $110 and does not include the cost of laboratory tests or prescription items. All services by a Pharmacist are exempt from HST.

OHIP does *not* cover these consultation fees. However, some people will qualify for OHIP-covered MedsCheck programming conducted by their *own* Pharmacist. If you do not have a Pharmacist, Tarek Hussein will be pleased to assist you at Weller Pharmacy, in Kingston. The MedsCheck program is not available at KIHC. You can read more about this program on the Government of Ontario website: www.health.gov.on.ca/en/pro/programs/drugs/medscheck/medscheck_original.aspx

STATEMENT OF ACKNOWLEDGEMENT

I will inform my Pharmacist of all health conditions, 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 Pharmacist if I am pregnant or breastfeeding.

I understand that I am entitled to know about my treatment, 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 he has answered all of my questions to the best of his ability.

I understand that there may be health risks associated with some pharmaceutical treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or drugs, and bruising or injury from injections. I understand that my Pharmacist is unable 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. 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 Clinical Pharmacist during your appointments will be handled in accordance with current privacy legislation and standards determined by the regulatory body. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Clinical Pharmacist, 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 Tarek Hussein, Registered Pharmacist, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

_____ _____

NAME DATE

_____ _____

SIGNATURE WITNESS