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
- Counselling
- Holistic Nutrition
- Reiki and Bioenergy
- Homeopathy
- Medical testing
- Community Workshops

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

All 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 blood work or 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 naturopathic medical practice? _____

Emergency contact information:

Name: _____ Relationship: _____ Tel: _____

Please circle the name of the Naturopathic Doctor you are seeking healthcare services from:

Dr. Sonya Nobbe Dr. Angela Hunt Dr. Oscar Hernandez

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

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

_____

When was your last physical exam? _____

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: _____
4. _____ 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: _____
4. _____ Date started: _____ Dose: _____

Please list all medications, pharmaceuticals, or supplements 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: _____

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): _____

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LIFESTYLE

Please describe a typical day's diet:
Breakfast: _____
Lunch:_____
Dinner: _____
Snacks: _____
Beverages: _____

How much and 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 (if retired, please specify occupational history)? _____

Please list some of your hobbies: _____

Please briefly describe your travel history:_____

_____

Do you have any children or elderly living in your home? _____

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

Are you *or were you ever* regularly exposed to any of the following at home or work (please circle)?

Tobacco smoke Chemicals/toxins Animals Radiation Well water

Please describe: _____

Have you ever been exposed to a constant source of heavy metals or environmental contaminants (e.g. welding, stained glass making, farming, **manufacturing**)? _____

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? _____

_____

_____

Thank you.

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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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INFORMED CONSENT FOR TREATMENT

Naturopathic Medicine is a distinct system of primary care that addresses the whole body and underlying cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and time-tested healing knowledge. Naturopathic doctors integrate standard medical diagnostics with a broad range of natural therapies, including botanicals (herbs), acupuncture, clinical nutrition, counseling, and homeopathy. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your first naturopathic appointment will generally last 60 to 90 minutes and may include a physical exam and referral for laboratory tests or co-care. Follow-up appointments may range from 15 to 60 minutes each, according to your individual health requirements. The first consultation fee is $170 and does not include the cost of laboratory testing or prescription items. Follow-up consultations and associated fees vary according to your specific health requirements. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do. Services offered by Naturopathic Doctors are exempt from HST.

STATEMENT OF ACKNOWLEDGEMENT

I, _____, as a patient of _____, understand that the form of medical care is based on naturopathic principles and practices. I will inform my naturopathic doctor 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 naturopathic doctor if I am pregnant or breastfeeding.

I understand that I am entitled to know about my diagnosis and 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 she has answered all of my questions to the best of her ability.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, and bruising or injury from acupuncture.

I understand that my naturopathic doctor 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 Naturopathic Doctor during your appointments will be handled in accordance with current privacy legislation and standards determined by the regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Naturopathic Doctor, 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 _____, Doctor of Naturopathic Medicine, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

_____ _____
NAME DATE

_____ _____
SIGNATURE WITNESS