Welcome to our health facility.

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 that includes a physical, emotional, spiritual, social, and environmental component. Much of this philosophy came to the West as "Alternative" medicine and is now part of a broader, encompassing movement that includes mainstream medical science.

WE'RE QUALITY-OF-LIFE EXPERTS. Our integrative team of ten health professionals offers a variety of services designed to treat the whole person, whether for the short or long-term. Our patients request our services for a variety of reasons, including chronic pain or disease management, disease prevention, and drug or surgery alternatives. We work *with* the body's intrinsic healing ability to address underlying causes of illness and produce effective, long-lasting results. We take the time to help you understand your state of health and treat it safely.

DEVELOP A PERSONAL HEALTHCARE TEAM THAT SUPPORTS YOUR HEALTH PHILOSOPHY. With your permission, your KIHC health practitioner may consult other clinic professionals or refer you for co-care. However, you are welcome to explore the variety of healthcare services available here without a referral. ***All of our practitioners offer complimentary 15 minute introductory appointments*** to help you find the right professionals for your personal healthcare team. Our multi-disciplinary team includes Naturopathic Doctors, Registered Massage Therapists, an Osteopathic Manual Practitioner, Reiki and Brennan Healing Science practitioner, Psychotherapist, and Occupational Therapist. We also have an on-site medical laboratory, IV therapy room, acupuncture room, and workshop space for meditation, Qi gong classes, and health-specific education classes.

Up-to-date information about our services and educational workshops is offered in our free email newsletter which you may sign up for on our website, www.kihc.ca, or with our receptionists. Our team members write and share relevant health articles here in what we hope you'll find to be a fun and educational resource worth sharing.

Thank you for taking the time to complete the following new patient forms. They are an important step toward defining your healthcare needs and achieving your health goals.

Sincerely,

Kingston Integrated Healthcare Team

Explore your healthcare options… and discover your best self.

Kingston Integrated Healthcare Inc.
541 Palace Road, Kingston, ON K7L 4T6
613.547.KIHC • www.KIHC.ca

Kingston Integrated Healthcare
Phillip Wendt, Occupational Therapy
541 Palace Road Kingston, ON K7L 4T6
613.547.KIHC (5442)
www.kihc.ca

ADULT 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.

Name: _____ Date: _____

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

Address: _____

_____ Postal Code: _____

Home Tel: _____ Work Tel: _____ Email address: _____

Vocation: _____

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 receive care from:

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: _____

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Please check any specific occupational therapy interventions you have been referred for, or are interested in:

- ☐ Stress Management/Work Life Balance
- ☐ Fatigue Management/Energy Conservation
- ☐ CogMed™ Working Memory Training
- ☐ Home Safety/Accessibility Assessment
- ☐ Chronic Pain/Disability Management
- ☐ Progressive Goal Attainment Program (PGAP™)
- ☐ Walker/Scooter/Wheelchair Prescription
- ☐ Other: _____

Referring Practitioner:_____

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: _____
5. _____ Date started: _____ Date Resolved: _____

Please list any **medications and supplements** you are taking:

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

MOTOR VEHICLE ACCIDENT

Have you ever been in a motor vehicle accident? _____

_____

Where/When/How? _____

_____

Driver or Passenger? *(Please circle)* Were you wearing a seatbelt? Yes _____ No _____

What was the speed at impact? _____ Was anyone else in the vehicle? Yes ____ No ____

Where were you hit? Front _____ Back _____ Side _____ Diagonal _____

Related problems: _____

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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 the hardest thing to do in your day? _____
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

Do you use any mobility devices such as a cane or wheelchair (if yes, please describe)?_____
_____

Do you use any specialized equipment in your home such as a bath seat or bed rail (if yes, please describe)?_____
_____

Are you able to navigate your home and community without difficulty (if no, please describe)?___
_____
_____

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

Thank you.

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INFORMED CONSENT FOR TREATMENT

Occupational Therapists help you develop the skills needed for day-to-day activities when these abilities are reduced or lost because of injury, illness, chronic disease, mental health issues, developmental delays, learning problems, the impacts of getting older or other health factors. They work in partnership with other regulated healthcare providers to help ensure that you receive the most effective care possible.

Your first consultation generally lasts 75 minutes. Follow-up appointments may range from 15 to 60 minutes each, according to your individual health requirements. The first consultation fee is generally $125 and is exempt from HST. OHIP does *not* cover the fees of an occupational therapist, however many extended healthcare insurance providers do.

STATEMENT OF ACKNOWLEDGEMENT

I, _____, as a patient of Phillip Wendt, understand that the form of medical care is based on Occupational Therapy principles and practices. I will inform my Occupational Therapist 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 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 though occupational therapy treatments are generally safe and gentle, as I re-integrate activities into my daily routines there may be health risks associated, including but not limited to: aggravation of pre-existing symptoms.

I understand that my Occupational Therapist 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 Occupational Therapist during your appointments will be handled in accordance with current privacy legislation and standards determined by the College of Occupational Therapists of Ontario. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Occupational Therapist, 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 Phillip Wendt, Occupational Therapist, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

_____ _____

NAME DATE

_____ _____

SIGNATURE WITNESS