

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
- Psychotherapy
- Occupational Therapy
- 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.



GENERAL HEALTH INFORMATION

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: _____

Occupation: _____

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? _____

Please list all other healthcare practitioners you are seeing including your dentist:

1. _____ 2. _____ 3. _____

() _____ () _____ () _____

Present Conditions: Why have you come, what concerns you now?



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: _____

Do you have any other health concerns? _____

MEDICAL HISTORY

Please list any hospitalizations, surgeries (including dental), 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** you are taking, including health supplements, antacids, pain medications, and laxatives:

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 _____

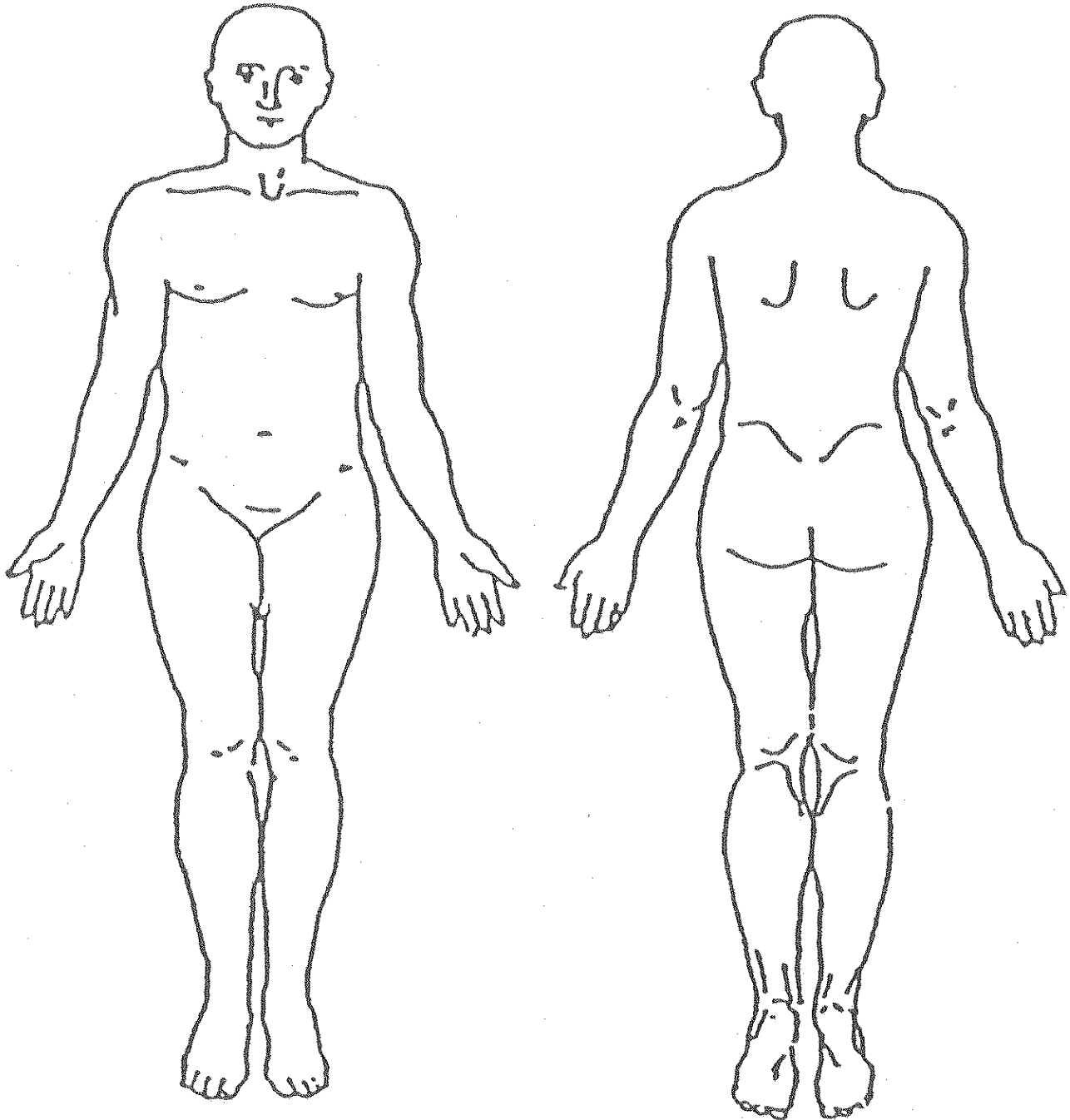
Driver or Passenger? _____ Were you wearing a seatbelt? Yes _____ No _____

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

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

Related problems: _____

Please draw on the diagram where you have symptoms:



DETAILED HEALTH HISTORY

GENERAL HISTORY

Headaches - When?
How often?
AM/PM
Migraines - When?
How often?
Fainting
Fatigue
Nervousness
Rashes, Irritations
Specific infections
Susceptible to colds or infections
Fever
Insomnia
Allergies
Cancer
Fibromyalgia
Coldness in extremities
Arthritis
Osteoporosis

NERVOUS SYSTEM

Numbness/Tingling
Convulsions (or related conditions e.g. seizures)

MUSCULAR-SKELETAL SYSTEM

Neck pain/Head pain
Whiplash
Sprains
Fractures
Falls
Joint pain Location: _____
Joint swelling Location: _____
Knee pain
Ankle pain
Carpal tunnel
Tennis elbow
Backache

RESPIRATORY SYSTEM

Chronic cough
Shortness of breath
Pneumo-thorax
Presence of phlegm
Pneumonia
Bronchitis/Asthma/Emphysema
Chronic Obstructive Pulmonary Disease (COPD)

CARDIOVASCULAR SYSTEM

High/low blood pressure
Heart attack
Chest pain
Angina
Arteriosclerosis
Varicose veins/phlebitis
Stroke
Aneurysm
Congestive heart failure

SPECIAL SENSES - EYES, EARS, NOSE & THROAT

Eyes

Surgery
Distorted vision
Glaucoma
Sensitive eyes

Ears

Infection
Dizziness
Ringing in ears

Nose

Surgery
Septal deviation
Trauma
Breathe easily
Sinus problems
Sinusitis

Throat

Trouble swallowing

TMJ

Jaw pain
Facial pain
Dental surgery
Mouth infections
Clicking or locking jaw
Restricted opening of jaw

URINARY SYSTEM

Bladder infection/dysfunction
Yeast infection

Kidney infection
Kidney disease
Diabetes
Urinate frequently
Difficulty urinating
Incontinence
Rectal bleeding

GASTRO-INTESTINAL SYSTEM

Loss of weight
Poor appetite
Ulcer
Gas, bloating
Vomiting
Pain over stomach before eating/after eating
Constipation
Diarrhea
Irritable bowel syndrome
Reflux
Colitis
Hemorrhoids
Nausea
Indigestion
Excessive hunger
Hiatal hernia

REPRODUCTIVE SYSTEM

Prostate
Erectile dysfunction
Sexually transmitted diseases
Infertility

Pregnancies

Number of pregnancies _____
Abortions _____
Miscarriages _____
Deliveries _____
 Labour
 Epidural
 Forceps

Menses

Regular
 Pain
 Medications
 PMS



Graham Wiltshire, CAT(C), CSCS, DOMP

541 Palace Road Kingston, Ontario K7L 4T6

613.547.kihc • www.kihc.ca

X Rays: _____

CAT scan: _____

MRI: _____

Are you receiving any treatment now? _____

EMOTIONAL HEALTH

What do you do to relax? _____

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? _____

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

Do you have any other problems that you feel a health practitioner should know about? Yes / No

Please explain: _____

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

Thank you.



INFORMED CONSENT FOR TREATMENT

Manual therapy is where the health practitioner places his or her hands on your body. Body and hand contact may include areas of your anterior chest wall, pelvis, pelvic floor, pubic bones, the face, and internal mouth. If you do not feel comfortable with any given technique, please tell the health practitioner **immediately**. The technique will be discontinued or modified to be comfortable for you.

Your first appointment will generally last 90 to 120 minutes and the fee is generally \$170. Follow-up appointments may range 60 to 90 minutes each according to your individual health requirements, and will cost \$115 to \$140. A combination of athletic therapy techniques and osteopathic manual techniques may be applied during your treatment. OHIP does *not* cover the fees associated with these treatments, however many private health insurance providers do. Services by Osteopathic Manual Practitioners are exempt from HST.

STATEMENT OF ACKNOWLEDGEMENT

I, _____, as a patient of Graham Wiltshire, understand that the form of health care is based on manual therapy principles and practices. I will inform my health 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 health practitioner 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 he has answered all of my questions to the best of his ability.

I understand that though manual therapy is generally safe and gentle, there may be health risks associated with some treatments, including but not limited to: aggravation of pre-existing symptoms and light-headedness.

I understand that my health practitioner 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, discontinue, or continue care from another healthcare provider.

SIGNATURE

DATE

WITNESS



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 health practitioner, Graham Wiltshire, 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.

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. Employees and health practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

Do you give permission for communication between Graham Wiltshire and:

Your referring healthcare professional? _____

Your family doctor? _____

Another individual or group? (Please list their names and relationship to you): _____

You have the right to withdraw consent for communication to any of the above persons at any time.

I have reviewed the above information and authorize Graham Wiltshire, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

NAME

DATE

SIGNATURE

WITNESS