# 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.

Sarah Knight, PhD, RM, EuBP

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# 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: ____________

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? ___________________________

Is this your first time receiving a Reiki or Bioenergy treatment? ________________

Emergency contact information:

Name: ________________ Relationship: __________ Tel: __________

## GOALS

What areas, concerns, or goals would you most like help with now?

| |
|---|
| 1. |
| 2. |
| 3. |
| 4. |

Kingston Integrated Healthcare

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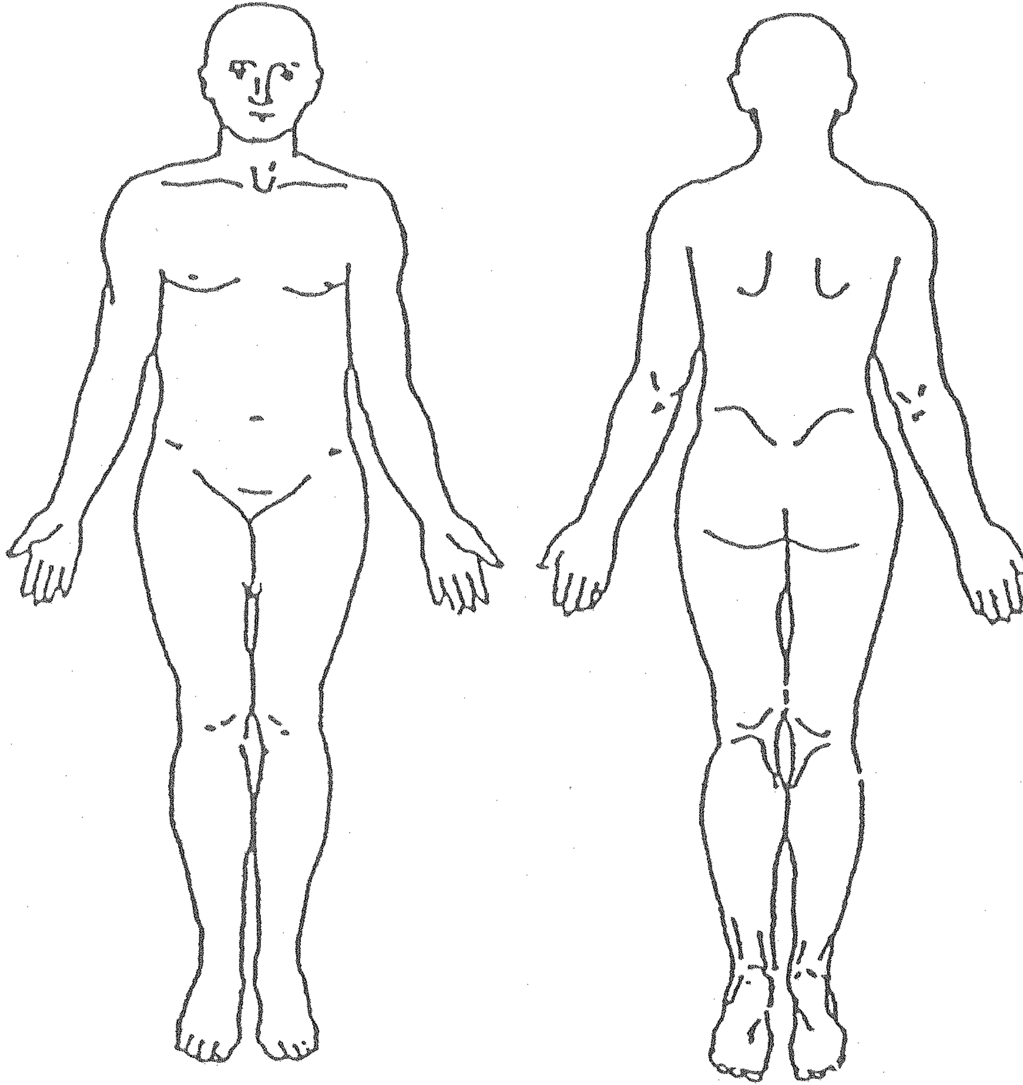
**Please draw on the diagram where you have symptoms, and rate the symptom from 1 (very mild), to 10 (severe):**



Apart from what you have listed above, are there any other issues that are of concern to you?

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

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## MEDICAL HISTORY

Please list all other healthcare practitioners you are seeing:

| Name: | Specialty: | Telephone: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Please list any hospitalizations, surgeries, and major illnesses you've experienced:

1. ________________________________ Date started: ______________ Date resolved: ____________
2. ________________________________ Date started: ______________ Date resolved: ____________
3. ________________________________ Date started: ______________ Date resolved: ____________
4. ________________________________ Date started: ______________ Date resolved: ____________

Please list any traumatic or life-threatening experiences:

1. ______________________________________________________________ Age/Date: ___________
2. ______________________________________________________________ Age/Date: ___________
3. ______________________________________________________________ Age/Date: ___________
4. ______________________________________________________________ Age/Date: ___________

Please list all **medications, supplements, or vitamins** you are currently taking:

1. ______________________________________________________________ Date Started: _________
2. ______________________________________________________________ Date Started: _________
3. ______________________________________________________________ Date Started: _________
4. ______________________________________________________________ Date Started: _________

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): ____________________________________________________________________

______________________________________________________________________________

At present, do you have any injuries, bruises, blood clots or varicose veins? Yes / No

Women Only: Are you pregnant? Yes / No/ Uncertain

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## LIFESTYLE

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

What is your relationship status? ____________________

On a scale of 1 (low) to 10 (high), please rate your overall level of stress: ____________________

Do you have an exercise routine? Please describe:

____________________

____________________

____________________

Do you do anything for relaxation? Please describe:

____________________

____________________

____________________

How many hours per night do you sleep on average? __________ Do you wake rested? *Yes / No*

How much and how often do you consume the following:

Alcohol: ____________________ Recreational Drugs:

Caffeine: __________ Water: __________ Tobacco: ____________________

What are your favourite foods? ____________________

What foods do you crave? ____________________

Briefly describe your dietary habits (e.g. Number of meals per day, type of food enjoyed):

____________________

____________________

____________________

Bowel movements: How often? _________time(s)/day or _________days/week

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## Energy And Emotional Health

On a scale of 1 (low) to 10 (high), please rate your overall energy level: ____________________

What time(s) of the day are your energy levels at their highest? ____________________

What time(s) of the day are your energy levels at their lowest? ____________________

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

How do you feel emotionally? ____________________

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

____________________

____________________

Any other comments regarding your energy levels and/or emotional and mental health? ________

____________________

____________________

____________________

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

____________________

____________________

____________________

*Thank you.*

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# INFORMED CONSENT FOR TREATMENT

As an energy work practitioner, my primary objective is to support you on your unique healing journey with competence, integrity and compassion. As a health practitioner, I facilitate your self-initiated process in your choosing to work with me. As well as working with your energy system, we may also work with areas that influence your overall state of well-being, including your health history, diet, exercise, life stressors, belief systems, and relationships. My intention is to create a safe, empathic, and life-affirming space to best facilitate your healing process. I am not trained to medically diagnose a disease condition, and I will work with the recommendations and care of your licensed medical professional(s).

The type of energy work that I do encompasses my two main areas of training: Reiki, and Bioenergy. This works clears, charges and rebalances the energy levels in your body, and I do this by using my hands, either on or off the body, in line with the training that I have received.

The first appointment lasts approximately 60-90 minutes, includes a health assessment and treatment, and costs $95. Follow-up treatments generally last 60 to 75 minutes and cost $80. OHIP does not cover this investment in your health; however, some insurance companies may provide some reimbursement.

STATEMENT OF ACKNOWLEDGMENT

I, ________________________________, in choosing to work with Sarah Knight, understand that the form of care is based on holistic, integrated therapeutic treatment. I have read and understand the information provided by Sarah and freely elect to have her work with me in the manner described above. I will inform Sarah of my 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 Sarah immediately if I am pregnant or breastfeeding.

I understand that I am entitled to ask questions about my treatment, including the costs, benefits, risks and potential side-effects. I choose to be fully active and responsible for my healing and wellness and will follow the recommendations given for self-care to the best of my ability.

I understand that though treatments are generally safe and gentle, there may be health risks or adverse reactions associated with some treatments, including but not limited to aggravation of pre-existing symptoms, heightened emotional reactions and sensitivity.

I acknowledge that I have had the opportunity to discuss my proposed treatment with Sarah and that she has answered all of my questions to the best of her ability. I understand that my 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 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 Sarah Knight during your appointments will be handled in accordance with current privacy legislation and standards. Personal health information includes identifiable information such as age, gender, family status, and health history.

Sarah Knight, employees, and 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 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.

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

| ______________________ | ______________________ |
|---|---|
| NAME | DATE |
| ______________________ | ______________________ |
| SIGNATURE | WITNESS |