

# 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
- Counselling
- Physiotherapy
- Holistic nutrition
- Homeopathy
- 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.**



### COUNSELLING CLIENT INTAKE FORM

Please bring this completed intake form with you to your first appointment. We welcome you to leave blank any answers you are uncomfortable disclosing. Your answers will remain confidential.

---

---

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Address: \_\_\_\_\_  
\_\_\_\_\_

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? \_\_\_\_\_

Emergency contact information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel: \_\_\_\_\_

Please list all other healthcare practitioners you are seeing:

- |           |           |           |
|-----------|-----------|-----------|
| 1. _____  | 2. _____  | 3. _____  |
| _____     | _____     | _____     |
| _____     | _____     | _____     |
| _____     | _____     | _____     |
| ( ) _____ | ( ) _____ | ( ) _____ |

Are you currently under the care of a medical doctor? Yes / No



**PRESENTING CONCERN:**

Briefly, what brought you here today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS TREATMENT:**

Have you ever sought counselling in the past? Please elaborate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What did you like or dislike about previous treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had hospital stays for psychological concerns? Please elaborate: \_\_\_\_\_  
\_\_\_\_\_

How do you currently cope with your stress? \_\_\_\_\_  
\_\_\_\_\_

Are you currently experiencing thoughts of harming either yourself or someone else? Yes / No

Have you in the past experienced thoughts of harming either yourself or someone else? Yes / No

**DEVELOPMENTAL HISTORY**

Where were you born? \_\_\_\_\_

Are you aware of any difficulties or complications during the time your mother was pregnant with you? \_\_\_\_\_

Were you born by C-section? Yes / No      Were you breast-fed as an infant? Yes / No /Uncertain

Do you feel you have completed normal life milestones (school, career, marriage, children, etc.) at appropriate times? \_\_\_\_\_

Are you satisfied with where you are in your life? Yes / No

If not, where would you like to be? \_\_\_\_\_  
\_\_\_\_\_



## MEDICAL HISTORY

Tell me about medical concerns you currently have, or have had in the past (e.g. chronic illness, allergies, digestive disorders, traumatic injuries, major surgeries, or chronic pain): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any **medications or supplements** you are taking, and why:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Purpose: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Purpose: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Purpose: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Purpose: \_\_\_\_\_

Have you ever struggled with substance abuse (e.g. alcohol, tobacco, marijuana, caffeine)? Yes / No

If yes, please describe (e.g. which substance and how often did you use): \_\_\_\_\_  
\_\_\_\_\_

Please elaborate on any treatment you may have received for substance use? \_\_\_\_\_  
\_\_\_\_\_

## DIET & LIFE STYLE

On a scale of 1 (poor) to 10 (excellent), how would you describe your overall physical health? \_\_\_\_\_

On a scale of 1 (poor) to 10 (excellent), how would you describe your overall sleep quality: \_\_\_\_\_

On a scale of 1 (poor) to 10 (excellent), how would you describe your overall diet: \_\_\_\_\_

Please describe your exercise routine (e.g. what kind, how often): \_\_\_\_\_  
\_\_\_\_\_

On average, how many hours of sleep do you achieve each night? \_\_\_\_\_

How many meals and snacks do you eat per day? \_\_\_\_\_

Please describe any special dietary needs, allergies, or sensitivities: \_\_\_\_\_  
\_\_\_\_\_

## OCCUPATIONAL HISTORY

What is your current employment status? Full-Time/Part-Time/Unemployed/Student/ Other

How satisfied are you with your employment (please describe): \_\_\_\_\_  
\_\_\_\_\_



**FAMILY HISTORY**

Please complete this table with reference to the **household you grew up in:**

Name & Relationship (e.g. Jane, mother)	Birth Order (siblings only)	General Characteristics (e.g. shy, angry, negative)	General Quality of your Relationship (e.g. close, conflicted)

Please complete this table with reference to your **current household:**

Name & Relationship (e.g. Jon, son)	Age	General Characteristics (e.g. shy, angry, negative)	General Quality of your Relationship (e.g. close, conflicted)



Please elaborate on any history of mental illness in your family: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Describe your childhood relationships with peers and friends: \_\_\_\_\_

How would you describe your current social support network? \_\_\_\_\_

Are these people who you can currently turn to in times of need? Please briefly elaborate: \_\_\_\_\_

\_\_\_\_\_

**EDUCATIONAL HISTORY**

What is the highest educational level you completed? \_\_\_\_\_

Please provide any additional important educational information (e.g. Did you like school? Have a learning disability?) \_\_\_\_\_

\_\_\_\_\_

**MARITAL HISTORY**

Which best describes your marital status? Married/Common-Law/Single/ Widowed/Separated/Divorced

If you are in a relationship, please briefly describe the nature of your relationship: \_\_\_\_\_

\_\_\_\_\_

**SPIRITUAL/RELIGIOUS BELIEFS**

Does religion or spiritual practice play an important role for you? Yes / No

If yes, please briefly elaborate: \_\_\_\_\_

**STRENGTHS**

Tell me about your strengths, hobbies, and interests. What do you like to do for fun? What are you good at? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything I did not ask that you thought I would, or anything else you think would be helpful for me to know? \_\_\_\_\_

\_\_\_\_\_

*Thank you*

## INFORMED CONSENT FOR COUNSELLING SERVICES

This document contains important information about Lindsay Dupuis's professional counselling services and business policies. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it represents an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counselling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counselling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your counsellor, I have corresponding responsibilities to you. These are described in the following sections.

**GOALS OF COUNSELLING:** There can be many goals for the counselling relationship. Some of these will be long-term goals such as improving the quality of your life or learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behaviours or decreasing/ending drug use. Whatever the goals for counselling, they will be set by you according to what you want to work on in counselling. The counsellor may make suggestions about how to reach that goal but, ultimately, you decide where you want to go.

**RISKS & BENEFITS OF COUNSELLING:** Counselling is an intensely personal process that can bring unpleasant memories or emotions to the surface. There are no guarantees that counselling will work for you. Clients may sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counselling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counselling. Counselling can help you develop coping skills, make behavioural changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

**APPOINTMENTS:** Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide the clinic with 24 hours' notice. *If you miss a session without canceling, or cancel with less than 24 hours' notice, a 50% cancellation fee may apply.* In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

**PROFESSIONAL FEES:** You are responsible for paying at the time of your session unless prior arrangements are made. If you refuse to pay your debt, your counsellor reserves the right to use an attorney or collection agency to secure payment. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case



requires my participation, you will be expected to pay for the professional time required.

**CONFIDENTIALITY:** Your counsellor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form. There are some limitations to confidentiality to which you need to be aware. Your counsellor may consult with a supervisor or other professional counsellor in order to give you the best service. In the event that your counsellor consults with another professional, no identifying information such as your name will be released. **Counsellors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counsellor receives a court order or subpoena, she may be required to release some information.** In such a case, your counsellor will consult with other professionals and limit the release to only what is necessary by law.

**CONFIDENTIALITY AND TECHNOLOGY:** Some clients choose to use technology in their counselling sessions. This includes but is not limited to online counselling via Skype, telephone, email, text or chat. Due to the nature of online counselling, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counsellor will take precautions to safeguard your information but cannot guarantee that unauthorized access to electronic communications will not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counselling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counselling sessions. Should you have concerns about the safety of your email, your counsellor can arrange to encrypt email communication with you.

**RECORD KEEPING:** Your counsellor may keep records of your counselling sessions and a treatment plan which includes goals for your counselling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed above. Records will be kept for at least 10 years either electronically on a USB flash drive or in a paper file, stored in a locked cabinet in the counsellor's office.

**CONTACTING ME:** For appointment booking, rescheduling or cancellations, please contact the administrative staff at Kingston Integrated Healthcare Inc.. I am often not immediately available by telephone on my private line. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. Alternately, you may send me an email and I will reply as soon as I can. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or dial 911.

---

Your signature below indicates that you have read this Agreement and agree to its terms:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date \_\_\_\_\_





**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 Lindsay Dupuis 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.

Lindsay Dupuis, 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 Lindsay Dupuis, employees, and health practitioners of 541 Palace Road to collect, use, and disclose my personal health information as outlined above.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS