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
- Osteopathy
- Physiotherapy
- Massage Therapy
- Acupuncture
- Pharmaceutical counseling
- 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 of our practitioners offer complimentary 15 minute introductory appointments to help you find the right professionals for your personal healthcare team.

Osteopathic Manual Therapy
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc • www.kihc.ca

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?

____

____

____

____

____

Osteopathic Manual Therapy
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

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 _____

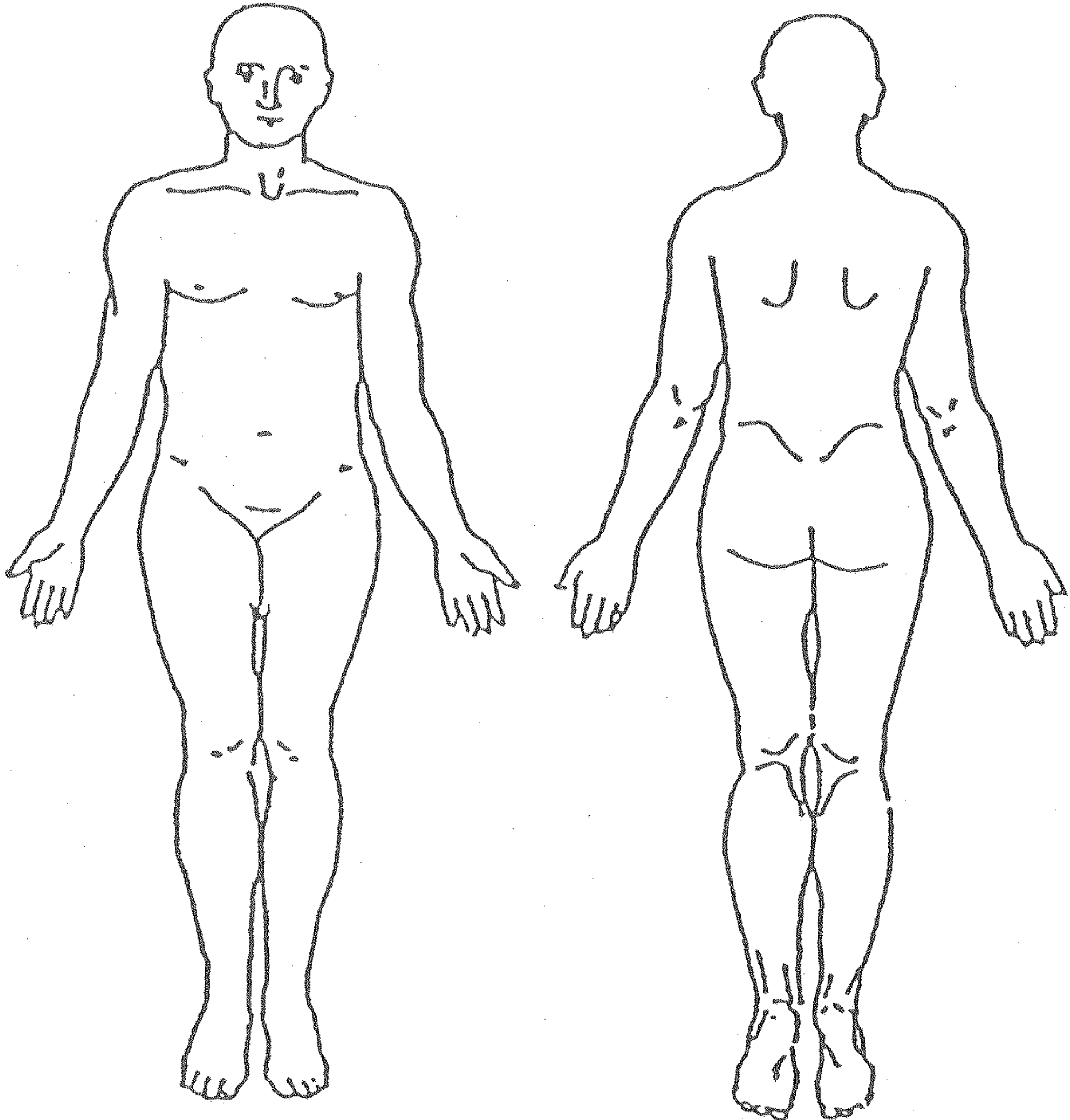
What was the speed at impact? ____________ Was anyone else in the vehicle? Yes _____ No _____

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

Related problems: ________________________

541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

Please draw on the diagram where you have symptoms:



Kingston Integrated Healthcare
Osteopathic Manual Therapy
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

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

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.

Osteopathic Manual Therapy
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

INFORMED CONSENT FOR TREATMENT

Manual therapy involves the health practitioner placing 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. OHIP does *not* cover the fees associated with these treatments, however some private health insurance providers do. Services by Osteopathic Manual Practitioners are exempt from HST.

STATEMENT OF ACKNOWLEDGEMENT

I, ________________________________, 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 s/he has answered all of my questions to the best of his/her 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

Osteopathic Manual Therapy
541 Palace Road Kingston, Ontario K7L 4T6
613.547.kihc ● www.kihc.ca

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 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 your Osteopathic Manual Practitioner 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