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
- Physiotherapy
- Acupuncture
- Clinical Pharmacy
- Holistic Nutrition
- 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.

Kingston Integrated Healthcare
Registered Massage Therapy
541 Palace Road Kingston, Ontario K7L 4T6
613.547.KIHC ● www.kihc.ca

HEALTH HISTORY FORM

The information requested below will assist us in treating you safely. Please ask any questions about the information being requested. All information will remain confidential except where required by law.

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? _____

Have you received massage therapy before? _____

How did you hear about this massage therapy practice? _____

Why are you seeking massage therapy? Please describe the location of any tissue or joint discomfort:

_____

_____

What is your general health status? _____

Emergency contact information:

Name: _____ Relationship: _____ Tel: _____

Please list all other healthcare practitioners you are seeing (including primary healthcare):

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

( ) _____ ( ) _____ ( ) _____

What is your occupation? _____

Please describe what forms of exercise you participate in, and how often:

_____

_____

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MEDICAL HISTORY

Please list any **hospitalizations**, **surgeries**, **traumas** or **major illnesses**:

1. _____ Date started: _____ Date Resolved: _____
2. _____ Date started: _____ Date Resolved: _____
3. _____ Date started: _____ Date Resolved: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:

- ☐ high/low blood pressure
- ☐ congestive heart failure
- ☐ heart attack
- ☐ phlebitis/varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

Respiratory:

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Head/Neck:

- ☐ history of headaches/migraines
- ☐ vision problems or vision loss
- ☐ ear problems or hearing loss

Infections:

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Women:

- ☐ pregnant, due: _____
- ☐ gynaecological conditions:

_____

Emotional Health:

On a scale of 1 (low) to 10 (high), how would you rate the following:

Stress level: _____

Energy level: _____

Happiness: _____

Other Conditions (please describe):

- ☐ loss of sensation: _____
  _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity:
  _____
- ☐ epilepsy
- ☐ cancer _____
- ☐ skin condition _____
- ☐ arthritis _____
- ☐ family history of arthritis
- ☐ osteoporosis
- ☐ bleeding disorder
- ☐ digestive concerns
- ☐ mental illness
- ☐ Other:

_____

_____

Do you have any internal **pins**, **wires**, **artificial joints**, or **special equipment** (please describe)?

_____

Please list all **medications and supplements**, and the reason for taking them:

1. _____ to treat/manage: _____
2. _____ to treat/manage: _____
3. _____ to treat/manage: _____

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

_____

Thank you.

DATE OF INITIAL INTAKE _____ **UPDATE – 2** _____

UPDATE - 1 _____ **UPDATE – 3** _____

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INFORMED CONSENT FOR TREATMENT

"The practice of massage therapy is the assessment of the soft tissue and joints of the body and the treatment and prevention of physical dysfunction and pain of the soft tissues and joints by manipulation to develop, maintain, rehabilitate or augment physical function, or relieve pain." *Massage Therapy Act, 1991*

All information collected is to help formulate a clinical understanding of your condition and will be kept confidential, except where required by law, or to facilitate a diagnosis. A signed consent form is required before I contact any other health provider for your personal health information.

An up to date and accurate health history is essential to the delivery of appropriate techniques associated with massage therapy treatments. Please advise me if you are receiving care from another health care provider for any condition, and provide me with a complete list of all medications, including over the counter drugs and supplements, to assist me in determining whether modifications to your treatment are required. Please inform me of any allergy or hypersensitivity reaction you may have to any oils, lotions, laundry detergents, fabric softeners etc.

An assessment of your condition or physical discomforts may be necessary to determine the best course of action for treatment and your first treatment has been allotted extra time for assessment purposes. Throughout the course of treatments, additional time for reassessments may be required and may cut into your appointment time.

Benefits of massage therapy services can include but are not limited to increased mobility, increased flexibility, decreased stress or anxiety, and relief of muscle or joint pain. **Potential risks and/or side effects** associated with massage therapy can include but are not limited to bruising, swelling, tissue congestion, nausea, dizziness, temporary muscle tenderness or soreness, and aggravation of existing symptoms.

After every massage treatment it is important to stay hydrated by drinking plenty of water to help flush out toxins released from the tissues during the massage, unless fluid intake is restricted by a physician. It is also advised that you apply cold to any tender or sore areas to decrease tissue congestion and chances of bruising.

Results vary from person to person depending on the goals of the individual. Following home care suggestions will help you achieve your goals; however, it may be necessary to seek out other health care providers to assist in achieving your health goals.

STATEMENT OF ACKNOWLEDGEMENT

I have read the above statement and acknowledge that I am able to withdraw my consent and discontinue treatment at any time. I understand that I have the right to ask any questions about any aspect of the assessment, treatment, and any of the information being collected, as it relates to me and my treatment plan. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

I accept full responsibility for any fees incurred during care and treatment, including a **50% late cancellation fee if I provide less than 24 hours' notice for cancelling my appointments**.

_____ _____ _____

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 Registered Massage Therapist 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.

Your Registered Massage 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 a portion of 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 my Registered Massage 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