



*Carol Belanger, BA(Biology), RMT*

541 Palace Rd. Kingston, ON K7L 4T6  
613-547-KIHC (5442)  
www.kihc.ca

## ADULT INTAKE FORM

*Every detail you provide will help you achieve your health goals and will remain strictly confidential. Please bring this completed form to your first appointment, complete with signed Informed Consent form, and Consent for Use of Private Information.*

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

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

Height: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Weight: \_\_\_\_\_

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? \_\_\_\_\_

Emergency contact information:

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

How did you hear about this health practice? \_\_\_\_\_

Please list all other healthcare practitioners/therapists you are seeing:

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

Please list your present primary health concerns, in order of importance:

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_

2. \_\_\_\_\_ Date of onset: \_\_\_\_\_

3. \_\_\_\_\_ Date of onset: \_\_\_\_\_

4. \_\_\_\_\_ Date of onset: \_\_\_\_\_



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## MEDICAL HISTORY

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 mark "C" for current conditions and "P" for any conditions you've had in the past 6 months:

- |                                       |  |   |  |   |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Hypertension     |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Upper back pain   | <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Malaria           | <input type="checkbox"/> Angina           |
| <input type="checkbox"/> Flatulence   | <input type="checkbox"/> Lower back pain   | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lyme disease      | <input type="checkbox"/> Heart attack     |
| <input type="checkbox"/> Indigestion  | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Pleurisy       | <input type="checkbox"/> Mononucleosis     | <input type="checkbox"/> Heart disease    |
| <input type="checkbox"/> Gastritis    | <input type="checkbox"/> Carpal tunnel     | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Ulcers       | <input type="checkbox"/> Depression        | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Kidney stones     | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Mood swings       | <input type="checkbox"/> Measles        | <input type="checkbox"/> Prostatitis       | <input type="checkbox"/> Liver problems   |
| <input type="checkbox"/> Migraines    | <input type="checkbox"/> Insomnia          | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Herpes            | <input type="checkbox"/> Jaundice         |
| <input type="checkbox"/> Headaches    | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Gonorrhea         | <input type="checkbox"/> Low blood sugar  |
| <input type="checkbox"/> Earaches     | <input type="checkbox"/> Eczema, Psoriasis | <input type="checkbox"/> Flu            | <input type="checkbox"/> HIV               | <input type="checkbox"/> High blood sugar |
| <input type="checkbox"/> Jaw pain     | <input type="checkbox"/> Dandruff          | <input type="checkbox"/> TB             | <input type="checkbox"/> Syphilis          | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> Thyroid      | <input type="checkbox"/> Fungal infection  | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Abnormal PAP      | <input type="checkbox"/> Epilepsy         |
| <input type="checkbox"/> Gout         | <input type="checkbox"/> Skin disorder     | <input type="checkbox"/> Fever          | <input type="checkbox"/> Endometriosis     |   |

Please list any **medications, supplements, or vitamins** you are taking, including antacids, pain medications, and laxatives:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
5. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
6. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
7. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_

Approximately how many times have you been treated with antibiotics? \_\_\_\_\_

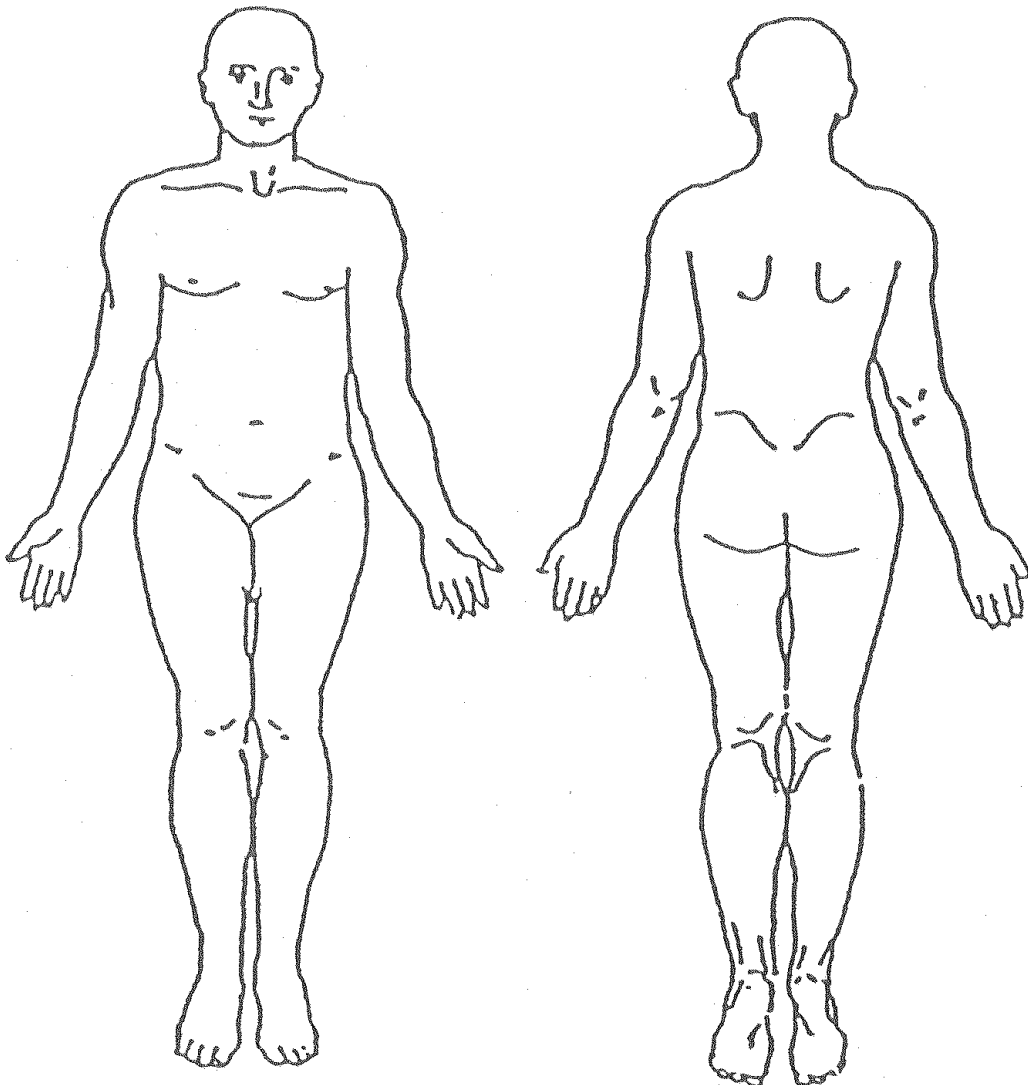
Please list any allergies, sensitivities, or adverse reactions (e.g. to medications, immunizations, food, chemicals, pets):

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





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## LIFESTYLE

Please describe a typical day:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

How often do you consume the following:

Alcohol: \_\_\_\_\_ Recreational Drugs: \_\_\_\_\_

Caffeine: \_\_\_\_\_ Water: \_\_\_\_\_ Tobacco: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your occupation? \_\_\_\_\_

Please list some of your hobbies: \_\_\_\_\_

Please briefly describe your travel history: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any children living in your home? Please indicate their age(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## EMOTIONAL HEALTH

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

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

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

How would you describe the emotional climate of your home? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you feel that your home is a safe place? \_\_\_\_\_

Have you ever felt sad or depressed for two weeks or more at a time in the past year? Yes No

Do you have any comments regarding your emotional or mental health (please describe)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



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## ENVIRONMENT

Are you regularly exposed to any of the following at home or work:

**Chemicals** (e.g. tobacco smoke, perfumes, household cleaners, room deodorizers, air fresheners, new carpeting, paint fumes): \_\_\_\_\_

**Radiation** (e.g. regular computer use, high tension wires near home): \_\_\_\_\_

**Heavy metals** (e.g. welding, stained glass making): \_\_\_\_\_

**Infectious agents** (e.g. pets, mold): \_\_\_\_\_

**Other:** \_\_\_\_\_

## FAMILY HISTORY

Please indicate whether the following health conditions **pertain to any of your family members**:

Condition	Relative	Age of Onset	Details
Heart problems (e.g. high blood pressure)			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. Crohn's disease)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Autoimmune disease (e.g. lupus, arthritis)			
Mental illness (e.g. depression)			
Difficulties with drugs and/or alcohol			
Other			

What do you hope to accomplish today, and long-term, with this work? \_\_\_\_\_

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



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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. We will 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.

Advanced reiki therapy incorporates energy work skills and approach from several modalities including Brennan Healing Science, Reiki, and Qi Qong. This works clears, charges and rebalances the energy levels in your body. I will be doing the energy work with my hands primarily on the joints, spine and above the major organs of the body. I can do this work either with my hands on the body or off the body while you lie fully-clothed on a treatment table.

The first appointment lasts approximately 60-75 minutes, includes a health assessment and treatment, and costs \$75. Follow-up treatments generally last 60 minutes and cost \$60, or 45 minutes and cost \$45. OHIP does not cover this investment in your health however some insurance companies do provide some reimbursement.

### STATEMENT OF ACKNOWLEDGMENT

I, \_\_\_\_\_, in choosing to work with Carol Belanger, understand that the form of care is based on holistic, integrated therapeutic treatment. I have read and understand the information provided by Carol and freely elect to have her work with me in the manner described above. I will inform Carol 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 Carol 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, including no alcohol use for 24 hours following treatment.

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 Carol 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. 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 Carol Belanger 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.

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

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS