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 health professionals offering expertise in complementary, alternative, and integrative medicine.

- Naturopathic Medicine
- Massage Therapy
- Osteopathy
- Acupuncture
- Psychotherapy
- Occupational Therapy
- Reiki and Bioenergy
- Homeopathic Medicine
- 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

Homeopathic Medicine (Pediatric)

541 Palace Road Kingston, Ontario K7L 4T6

613.547.5442 ● www.kihc.ca

PEDIATRIC INTAKE FORM (UP TO 12 YEARS)

Every detail you provide on this form will remain confidential and will contribute to achieving your child's health goals. Where possible, we ask that the child's primary caregiver fill out this form.

Child's name: _____ Height: _____ Weight: _____

Age: _____ Date of birth: _____ Gender: _____

Child's address: _____

_____ Postal Code:_____

Home Tel: _____ Please indicate your relationship to the child: _____

PARENT/GUARDIAN CONTACT INFORMATION

Name: _____

Address: _____

Home Tel: _____ Work Tel:_____ Email: _____

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 naturopathic medical practice?_____

Emergency contact information:

Name: _____ Relationship: _____ Tel:_____

Please list all other practitioners on your child's healthcare team (e.g. medical doctor, dentist, etc.):

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
( ) _____	( ) _____	( ) _____

Please list your primary concerns about your child, in order of importance:

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____

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MEDICAL HISTORY

Please list your child's hospitalizations, surgeries, traumas or major illnesses:

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

Do you believe that any of these experiences still negatively influence your child's life: _____

_____

Please indicate which of the following immunizations was received **and *when*:**

O DTP: _____ O Hep A: _____ O Pneumococcal: _____
O Polio: _____ O MMR: _____ O Meningococcal: _____
O Hib: _____ O Varicella: _____ O Influenza (flu): _____
O Hep B: _____ O HPV: _____ O Other:

Please describe any complications or reactions to the immunizations: _____

_____

Please list any allergies, sensitivities, or adverse reactions your child may have (e.g. to medications, food, scents): _____

_____

Please list any medications or supplements (e.g., vitamins, herbs, homeopathics) your child is **currently taking**:

1. _____ Date started: _____ Dose: _____ Time of day: _____
2. _____ Date started: _____ Dose: _____ Time of day: _____
3. _____ Date started: _____ Dose: _____ Time of day: _____
4. _____ Date started: _____ Dose: _____ Time of day: _____

Please list any medications or supplements your child has taken **in the past**:

1. _____ Date started: _____ Completed: _____
2. _____ Date started: _____ Completed: _____
3. _____ Date started: _____ Completed: _____
4. _____ Date started: _____ Completed: _____

Approximately how many times has your child been treated with antibiotics? _____

Prenatal History

Were there any complications during the pregnancy (e.g. nausea and vomiting, high blood pressure, gestational diabetes)? _____

_____

What medications (including supplements, herbs, recreational drugs or alcohol) did the birth mother take during pregnancy?

1. _____ Dose:_____ Reason: _____
2. _____ Dose:_____ Reason: _____
3. _____ Dose:_____ Reason: _____

Did the birth mother experience any illness, traumas, or hospitalizations during her pregnancy?

1. _____ Date of onset: _____
2. _____ Date of onset: _____

Natal History

Your child's delivery was (please circle): Vaginal C-section Induced Early Late

Your child was delivered at (please circle): Home Hospital Other

Were there any complications during labour and/or delivery? Please describe: _____

_____

_____

Please indicate your child's weight at birth: _____ Length: _____

Breastfeeding History

How long was your child breastfed? _____At what age were solid foods introduced? _____

Did any complications occur with breastfeeding or the introduction of solid foods? _____

_____

Developmental History

Please describe any concerns you have about your child's behaviour or development: _____

_____

_____

At what age did your child experience the following milestones:

Lift his/her head alone: _____
Roll over:_____
Crawl: _____
Develop his/her first tooth: _____
Walk (with hand held): _____
Speak his/her first word: _____

LIFESTYLE

Please describe a typical day's diet:

Breakfast: _____

Lunch:_____

Dinner: _____

Snacks: _____

Beverages: _____

Please describe what forms of exercise your child participates in, and how often:

_____

_____

_____

How many hours does your child sleep each night? _____

How many times does he/she wake up in the middle of the night? _____

How often does he/she experience nightmares? _____

Please give a brief description of your child's daily routine (e.g. do they attend daycare, public school, wake/sleep schedule etc.):

_____

_____

_____

_____

Where has your child traveled to outside of this country? _____

What (if any) pets reside in the child's home? _____

ENVIRONMENT

Was or is your child *ever* regularly exposed to any of the following (please circle)?

Tobacco smoke Chemicals/toxins Radiation Well water

Please describe: _____

Has your child or child's birth mother **ever** been exposed to a constant source of heavy metals or environmental contaminants (e.g.stained glass making, farming, **manufacturing**)?_____

_____

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EMOTIONAL HEALTH

Has your child suffered any emotional trauma (e.g. divorce, death, moving homes)? _____

_____

Do you have any concerns regarding your child's emotional or mental health (please describe)? ____

_____

_____

Does your child have any other problems that you feel a health practitioner should know? Yes / No

Please explain: _____

_____

FAMILY HISTORY

Please indicate whether the following health conditions **pertain to anyone in your child's family:**

Condition	Relative	Age of Onset	Details
Heart problems or stroke (e.g. high blood pressure)			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. lactose intolerance)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Autoimmune disease (e.g. Type I Diabetes, lupus, Crohn's disease)			
Mental illness (e.g. depression)			
Difficulties with drugs and/or alcohol			
Other: (e.g. birth defect, Lyme disease, bleeding disorder)			

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

_____

Thank you.

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INFORMED CONSENT FOR TREATMENT

Homeopathy is a system of natural medicine that has a distinct philosophy and methodology. It provides a similar stimulus to the natural symptom presentation, or "Like cures Like". A homeopath selects the best remedy based on the unique needs of each individual, and prescribes only the smallest amount needed, or the "minimum dose", to direct the inner healing mechanism. Homeopaths do not diagnose disease and so they work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your child's first homeoopathic appointment will generally last 60 minutes and may include a physical exam and referral for co-care. Follow-up appointments may range from 15 to 60 minutes each, according to your child's individual health requirements. The first consultation fee is $120 plus HST, (age 2-12) age, or $80 plus HST, (under age 2), and includes the cost of the homeopathic remedy. OHIP does *not* cover the fees of a registered homeopath, however many extended healthcare insurance providers do. Services offered by Registered Homeopaths are recognized as a medical expense by CRA and can be used for tax purposes.

STATEMENT OF ACKNOWLEDGEMENT

As the parent or legal guardian of _____, I, _____, understand that the form of medical care provided is based on homeopathic principles and practices. I will inform my homeopath 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.

As the parent or legal guardian of _____, I understand that I am entitled to know about my child's homeopathic 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 always at liberty to seek or continue care from another qualified healthcare provider. I am encouraged to request more information as needed, and to take an active role in my child's care. I acknowledge that I have had the opportunity to discuss my child's proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I understand that though homeopathic treatment is generally safe and gentle, there may be health risks associated with some homeopathic treatment, including but not limited to aggravation of pre-existing symptoms.

I understand that a homeopath 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.

_____ _____
FULL NAME OF PATIENT DATE

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN WITNESS

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CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Health privacy for you and your child is a primary concern for us. The personal health information you disclose to your Homeopath will be handled in accordance with current privacy legislation and standards determined by the regulatory body, the College of Homeopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Homeopath, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you and your child for the following purposes:

- To assess your child's 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 and your child;
- 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 Sarah Hutchinson, Registered Homeopath, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information and that of my child, as outlined above. I acknowledge that I have the legal authority to do this on behalf of my child.

_____ _____

NAME DATE

_____ _____

SIGNATURE WITNESS