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
- Mental Health Therapy
- Speech-Language Pathology
- Medical Nutrition
- Shamanic healing
- Ayurveda
- Medical testing
- Community Workshops

With your permission, your KIHC health practitioner might consult other clinic professionals or refer you for co-care.

All practitioners offer complimentary 15-minute introductory appointments to help you find the right professionals for your personal healthcare team.

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

PEDIATRIC INTAKE FORM

Name: ______________________________ Date: ______________

Date of birth (dd/mm/yy): ______________ Age: ______ Gender: ____________

Parent/Caregiver name(s): ______________________________

Parent/Caregiver occupation(s): ______________________________

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? ______________________________

How did you hear about this speech-language pathology practice? ______________________________

Please describe your concerns and/or goals related to your child's communication:

1. ______________________________
   ____
2. ______________________________
   ____
3. ______________________________
   ____

SOCIAL HISTORY

Who does this child live with (circle all that apply): Birth parent(s)/ Adoptive parent(s)/ One parent/ Parent and step-parent/ Foster parent(s)/Other: ______________________________

Is there a custody agreement or other legal concern relevant to the care of this child? __________

Please list members of your household **and any other frequent communication partners** your child has. **Include their relationship to your child and ages of all siblings**:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

5. ______________________________
6. ______________________________

Please provide details of any family member with the following health history:

Speech language difficulties (e.g., stuttering): ______________________________

Learning disabilities (e.g., dyslexia): ______________________________

Hearing impairment: ______________________________

What is the primary language spoken at home? ______________________________

What other languages is your child regularly exposed to? ______________________________

Birth History

Was your child healthy at birth? Please explain: ______________________________

Was your child born prematurely? If yes, please indicate how many weeks: ______________

Was your child exposed to smoke, alcohol, or drugs before birth? Please explain: ______________

____

Medical & Developmental History

Has your child experienced any of the following health concerns or procedures? (Check all that apply)

- ☐ Frequent ear infections or earaches
- ☐ Tonsillitis
- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Tubes in ears
- ☐ Difficulty sleeping
- ☐ Snoring
- ☐ Breathing difficulties (including asthma)
- ☐ Frequent nasal congestion
- ☐ Frequent colds or flu
- ☐ Allergies
- ☐ Vision problems
- ☐ Wears glasses
- ☐ Head injury
- ☐ Convulsions/seizures
- ☐ Meningitis
- ☐ Confirmed strep infection

Please describe any other medical or genetic diagnoses: ______________________________

____

Please describe any additional medical information (e.g., surgeries, hospitalizations): ______________

____

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Please list all medications AND supplements your child is taking:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Please indicate date, location, and results of the following:

Most recent hearing test: ______________________________

Most recent vision test: ______________________________

Have you ever had concerns (past or present) about other areas of your child's development?

Eating: ______________________________

Sleeping: ______________________________

Moving: ______________________________

Learning: ______________________________

Behaviour: ______________________________

Attention: ______________________________

Other: ______________________________

Provide details *including relevant test results and outcomes* of appointments with any of the following specialists:

Pediatrician: ______________________________

Ear, Nose, Throat (ENT) Physician: ______________________________

Psychologist: ______________________________

Speech-Language Pathologist: ______________________________

Occupational Therapist: ______________________________

Vision specialist: ______________________________

Dentist: ______________________________

Orthodontist: ______________________________

Other: ______________________________

Is your child currently involved with services in the community (e.g., KidsInclusive, Maltby Centre, Community Living Kingston, etc.)? ______________________________

____

____

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FEEDING & EATING HISTORY

Has your child experienced any of the following health concerns? (Check all that apply)

- ☐ Thumb/finger sucking: ____________________
- ☐ Pacifier use: ____________________
- ☐ Difficulty nursing/breastfeeding: ____________________
- ☐ Reflux/colic: ____________________
- ☐ Tongue thrust: ____________________
- ☐ Messy eater: ____________________
- ☐ Picky eater: ____________________
- ☐ Food texture sensitivity: ____________________
- ☐ Drooling: ____________________
- ☐ Tongue or lip tie: ____________________
- ☐ Food allergies: ____________________
- ☐ Choking or coughing while eating: ____________________

Does your child breathe primarily through their nose or mouth? ____________________

EDUCATIONAL & ACADEMIC HISTORY

What is the name of your child's school or childcare program? ____________________

Is your child enrolled in specialized school programs (e.g., French Immersion, “School to Community”)?

____

Does your child have an IEP? ____________________

Does your child receive any other therapies outside of school? ____________________

Does your child experience difficulty reading (if applicable)? ____________________

Is your child receiving any other help for school (e.g., tutoring)? ____________________

COMMUNICATION SKILL DEVELOPMENT

Does your child prefer to communicate with gestures, words, neither, or both? ____________________

Indicate the approximate age at which your child reached the following milestones:

- ☐ Sitting: ____________________
- ☐ Walking: ____________________
- ☐ Babbling: ____________________

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- ☐ First words: ______
- ☐ Pointing with index finger: ______
- ☐ Two-word combinations: ______
- ☐ Feeding on their own: ______

Please explain:

Do you consider any milestones to be delayed or impaired? ______

Was your child a quiet infant (limited vocalizations / babbling)? ______

Has your child seen a speech-language pathologist in the past? (Who, where, etc.) ______

Is your child aware of or frustrated by any speech or language difficulties? ______

Does your child understand who, what, where, and why questions? ______

Does your child create long sentences using 5-8 words? ______

Does your child talk about past events (e.g., what you did last weekend)? ______

Does your child tell simple stories? ______

Does your child engage in multi-step pretend play? ______

Is your child's speech understood by most people most of the time? ______

Does your child look at you when you call their name? ______

Does your child follow simple directions? ______

Does your child follow complex or multi-step directions? ______

Does your child ask questions? ______

Please share with me something about your child's interests (e.g., activities, toys, topics, etc.): ______

______

______

Please provide some examples of what your child is saying (sounds, words, sentences): ______

______

______

Please share anything else you feel will support a successful first visit: ______

______

______

Thank you.

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INFORMED CONSENT FOR TREATMENT

Speech-Language Pathologists (S-LPs) are uniquely trained to screen, assess, and treat a variety of communication disorders. They work in partnership with other regulated healthcare providers to ensure that clients receive the most effective care possible.

Your child's first appointment will generally last 60 to 90 minutes. Follow-up appointments may range from 30 to 60 minutes each, according to individual health requirements. The first consultation fee is $180. OHIP does not cover the fees of a Speech-Language Pathologist, however many extended healthcare insurance providers do. Services offered by S-LPs are exempt from HST.

STATEMENT OF ACKNOWLEDGEMENT

As the parent/legal guardian of this child, I understand that the form of healthcare is based on Speech-Language Pathology principles and practices. I will inform my Speech-Language Pathologist (S-LP) 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/legal guardian of this child, I understand that I am entitled to know about my child's assessment and treatment, including the expected costs, benefits, and risks. 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 child's care.

I acknowledge that I have had the opportunity to discuss the proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability. I understand that my child's S-LP 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.

FULL NAME OF CHILD	DATE
SIGNATURE OF PARENT OR LEGAL GUARDIAN	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 Speech-Language Pathologist (S-LP) during your appointments will be handled in accordance with current federal privacy legislation and standards determined by the provincial regulatory body. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your SLP, 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 ____________________________, Speech-Language Pathologist, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

________________________________	________________________________
NAME	DATE
________________________________	________________________________
SIGNATURE	WITNESS