CCNM Canadian College of Naturopathic Medicine | Integrative Cancer Centre

Initial Health History Questionnaire

Welcome to the CCNM Integrative Cancer Center. *Please read and complete this form to the best of your ability and either email to iccinfo@ccnm.edu or fax (647)689-5794 before your first visit. The following document outlines important information to help us best address your health and the required consent to be able to treat you and protect your privacy. You will be required to sign four separate pages near the end of this form.* ***Thank you for completing this form; your care is our priority.***

Personal Information: **Date:** (DD/MM/YYYY)_____

Last name:_____First name:_____Age: _____

Date of Birth (DD/MM/YYYY):_____Gender:_____Preferred pronoun: _____

Address: _____ City:_____Province:_____Postal code:_____

Home: (_____)_____-_____Work: (_____)_____-_____Cell: (_____)_____- _____

Email address:_____Occupation: _____

Emergency Contact:_____Relationship:_____Telephone: _____

Family Doctor:_____Family Doctor Clinic Name/Address: _____

Medical Oncologist:_____Radiation Oncologist: _____

Surgeon:_____Other(s) (specialty): _____

Do you have any mobility issues? Y☐ N ☐ If yes, please describe (ex. Wheelchair, unable to use stairs, etc.)

_____

How did you hear about the CCNM Integrative Cancer Centre?

_____

What is the main reason for your visit to the CCNM ICC?

_____

_____

_____

Cancer Specific Information

Cancer status: ☐ I am dealing with cancer now (Is this a recurrence of the same cancer? Y ◯ N ◯)
☐ I want to avoid cancer coming back
☐ I want to prevent cancer in the first place

If you have ever had a cancer diagnosis:

What type(s) (e.g. breast, colorectal, lung, lymphoma, etc): _____

Stage (if known): _____ Date of diagnosis: _____

Cancer treatments

Treatment (Tx)	Type (if known/applicable)	Last Tx Date (DD/MM/YYYY)	Please describe any significant complications or side effects
☐ Biopsy			
☐ Surgery			
☐ Chemotherapy			
☐ Chemotherapy			
☐ Radiation			
☐ Hormone therapy			
☐ Other			

Past screening tests and exams

Exam	Date (DD/MM/YYYY)	Normal result?
Mammogram (women)		☐ Y ☐ N
Pap test (women		☐ Y ☐ N
Colonoscopy		☐ Y ☐ N
Blood in stool		☐ Y ☐ N

Exam	Date (DD/MM/YYYY)	Normal result?
Prostate exam (men)		☐ Y ☐ N
Blood sugar		☐ Y ☐ N
Annual physical exam		☐ Y ☐ N
Bone density (DEXA)		☐ Y ☐ N

Past Hospitalizations

Year	Reason

Past Surgeries

Year	Type of surgery

Family health history please check the relevant boxes or check if family history unknown ☐

Condition	Mother	Father	Sibling (s)	Maternal Grandparent	Paternal Grandparent
Cancer (specify type)	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
Autoimmune disease	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐

Other Health Information

Please select any relevant diagnoses or health concerns. Provide more information at the end of the form if needed.	**Check if no concerns**
Allergies: ☐History of anaphylaxis. List known allergies: _____	☐
Cardiovascular: ☐Heart attack, ☐Stroke, ☐High/low BP, ☐High cholesterol, ☐Pacemaker, ☐Heart failure	☐
Respiratory: ☐Asthma, ☐Bronchitis, ☐Chronic cough, ☐Emphysema, ☐Shortness of breath	☐
Infections: ☐Chronic infections, ☐Hepatitis, ☐Tuberculosis	☐
Head and Neck: ☐Headaches/migraines, ☐Vision problems, ☐Hearing problems, ☐Tinnitus, ☐Head Injury	☐
Endocrine: ☐Diabetes, Type:_____Do you use insulin?:_____, ☐Thyroid (hyper/hypo)	☐
Digestion: ☐Kidney stone (last occurrence:_____), ☐Gas/bloating, ☐Reflux, ☐Constipation, ☐Diarrhea	☐
Reproductive: ☐Menopausal, ☐Pregnant (due:_____), ☐Planning to conceive, ☐Menstrual issues	☐
Neurological/Musculoskeletal: ☐Tingling/loss of sensation, ☐Multiple Sclerosis, ☐Rheumatoid/osteoarthritis, ☐ Epilepsy, ☐Fibromyalgia	☐
Sexual health: ☐Pain with sexual activity, ☐erectile difficulties, ☐loss of libido, ☐vaginal dryness	☐
Mental Health: ☐Anxiety, ☐Depression, ☐Trauma, ☐Psychiatric diagnosis	☐
Other: ☐Anemia, ☐Hemophilia, ☐Skin conditions, any other concerns not covered above: _____	☐

Please list all medications and supplements/natural health products taken regularly:

Name of drug or supplement	**Reason for use**	**Start date**	**Dose** (amount and frequency)	**Prescribed by** (or "self")

Is there anything else that you feel is important for us to know?

_____

CCNM Integrative Cancer Centre CONSENT FOR CARE FORM

The CCNM Integrative Cancer Centre (ICC) offers a range of strategies for managing cancer and cancer-related symptoms, improving quality of life, primary and secondary cancer prevention, augmenting the immune system, stimulating healing in the body and treating the underlying cause of disease. CCNM ICC clinicians assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects related to health. Our clinicians work to identify risk factors in order to make recommendations to prevent disease and help you optimize your physical, mental and emotional environment.

A number of gentle, non-invasive techniques may be used to develop an individualized treatment plan that addresses your unique needs. In your initial appointments, you can expect a physical examination and history taking.

Because some therapies must be used with caution with certain conditions (such as pregnancy and breast feeding, liver disease, heart disease, kidney disease, autoimmune disease) it is very important that you inform your clinician of any other disease(s) you are suffering from, as well as any medications, drugs, supplements and natural health products you are taking. It is also important to inform you clinician of any allergies you may have.

There are potential health risks associated with the treatments offered at the CCNM ICC. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, or injury from venipuncture or acupuncture
- Fainting, or puncturing of an organ, from acupuncture
- Emotional or psychological distress

Please read the following:

- In the event of a medical emergency during treatment, I authorize the practitioner to take such measures as they consider to be in my best interest.
- I understand that results cannot be guaranteed.
- I understand that direct emails or telephone calls to the practitioners are discouraged as medical issues cannot be safely or appropriately assessed without an office visit (if this is not possible, a telephone conversation may be scheduled with your practitioner that will be billed at the same rate as an office visit).
- I understand that this is a multidisciplinary clinic and as such my file and case may be shared and/or discussed between practitioners.
- I understand the fees for this service apply to me, and that payment is due at each visit and that cancellations made under 24 hours will be billed the cancellation fee.
- I understand that this is a teaching clinic and there may be students and/or other practitioners attending and/or guiding the session for learning purposes.
- I understand that information from my medical record may be analyzed and presented for research purposes but that my identity will be protected and kept confidential.

If you have any questions related to this, please address them with your clinician directly:

Name (please print):_____ Date: _____

Signature*: _____

**By typing your name above, you are signing this application electronically*

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy and protection of your personal information is important to the CCNM Integrative Cancer Centre.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what the CCNM ICC is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of the naturopathic professions regulatory body.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION?

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options
- To establish and maintain contact with you
- To remind you of upcoming appointments
- To allow us to efficiently follow-up for treatment
- To invoice for goods and services
- To process credit card payments, collect unpaid accounts and follow up on billing as required
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- To be used for educational and research purposes (this includes case summaries/series, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances

I have reviewed the above information that explains how the CCNM ICC will use my personal information and the steps that the CCNM ICC is taking to protect my information.

I agree that the CCNM ICC can collect, use and disclose personal information about_____
as set out above in the information about the CCNM ICC's privacy policies. *(Patient Name)*

If you would like a third party (family member/friend/etc.) to be able to discuss your care and personal health information, please complete the chart below.

I authorize the CCNM ICC staff members to disclose my personal health information to:

Name of person(s) requiring access and relationship to self (e.g. partner, son, daughter, parent, friend, etc.)*:

*Unless specified in the chart above, all personal health information will be shared.

Do you give the ICC permission to contact you about research studies you may be eligible for? Y ☐ N ☐

Do you give the ICC permission to send consultation/progress notes to your conventional healthcare providers? Y ☐ N ☐

Name (please print):_____ Date: _____

Signature*: _____
**By typing your name above, you are signing this application electronically*

Policies and Guidelines

Please read and follow these policies and guidelines carefully in order to respect all patients, practitioners, and staff within the CCNM ICC:

- The reception desk is happy to serve your needs. In order to ensure the best service, please call the front desk at 416-498-9763. **Scheduling and health related concerns cannot be resolved by email.**

- Please provide us with at least 24 hours' notice of cancellation for any appointment; less than 24 hours' notice or missed appointments will be charged a $25 fee. For IV therapy appointments, a cancellation fee of $15 will be charged as well as the cost of the IV bag prepared for you (emergencies are exempt from this policy). Please cancel all appointments by speaking to clinic reception at 416-498-9763.

- To ensure we can provide timely care to our patients, please arrive on time for your appointment. Appointment times cannot be extended to accommodate patients arriving late.

- Medical records of health services provided will be kept confidential and not released unless so directed by you or as required by law. As an integrative facility, should you pursue care with multiple CCNM ICC practitioners you imply consent for all your CCNM ICC care personnel to access your medical records. You may explicitly withdraw this consent at any time. You may access your medical records at any time, and can be provided a copy of them upon request following payment of a modest fee.

- At this time, OHIP does not cover complementary and alternative medicine. Certain expenses may be eligible for reimbursement by private insurance plans, however the CCNM ICC cannot accommodate third party billing. Service fees apply to all patients upon the date of their visit. Those experiencing financial difficulty that may prevent or inhibit their treatment options are encouraged to ask about fee subsidization.

- The CCNM ICC is a teaching clinic for the advancement of integrative cancer care and hosts clinic interns on a regular basis. You may be asked, but have the right to refuse, to allow an intern to observe your visit or a resident extern to be involved in your care.

- The CCNM ICC is a research facility, and conducts studies in integrative oncology. Information from your medical records may be analyzed and published for research purposes, but your identity will be protected and kept confidential. You have the right to refuse participation in this research.

- Unless explicitly requested not to, the CCNM ICC may communicate directly with your oncologist, surgeon, or other health care providers to inform and collaborate regarding your care. CCNM ICC practitioners will strive to obtain consensus with other health care providers regarding treatment plans, but ultimately the patient is responsible for directing and choosing their integrative care plan.

Email Communications:

In order to receive email communications related to treatment at the CCNM ICC, patients must be aware of the following risks:

- The privacy and security of email cannot be guaranteed: employers and online services may have a legal right to inspect and retain emails that pass through their systems and it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- If the patient's email requires or invites a response from the CCNM ICC and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The patient is responsible for informing the CCNM ICC of any types of information the patient does not want sent by email.
- The CCNM ICC will use reasonable means to protect the security and confidentiality of email information sent and received; however, because of the risks just outlined, the CCNM ICC cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct by its staff or interns.
- Although CCNM ICC clinicians will endeavor to read and respond promptly to patient emails, the CCNM ICC cannot guarantee that any particular email will be read and responded to within any particular period of time. Accordingly, patients should not use email for medical emergencies or other time-sensitive matters.

☐ Please check this box if you would like to receive the CCNM Integrative Cancer Centre **MONTHLY NEWSLETTER** with information about upcoming events, updates on integrative cancer support as well as tips and ideas for our patients.

I acknowledge that I understand and agree to abide by the above policies and guidelines during the course of my treatment at the CCNM Integrative Cancer Centre.

Name (please print):_____ Date*:* _____

Patient Signature*:_____

**By typing your name above, you are signing this application electronically*