OICC
OTTAWA INTEGRATIVE CANCER CENTRE

CCIO
CENTRE DE CANCÉROLOGIE INTÉGRATIVE D'OTTAWA

Initial Health History Questionnaire

Welcome to the OICC. *Please read and complete this form to the best of your ability and send in 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 three separate pages near the end of this form. If you have any questions do not hesitate to ask.* ***Thank you for completing this form; your care is our priority.***

Date: (DD/MM/YYYY) _____ /_____ /_____

Personal Information

Last name: _____ First name: _____ Age: _____

Date of Birth: (DD/MM/YYYY) _____ /_____ /_____ Gender: _____ Preferred pronoun: _____

OHIP number: _____ OHIP version code: _____
**Required to cover fees for visits with any of our medical doctors*

Street Address:_____

City: _____ Province: _____ Postal code: _____

Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

E-mail address: _____ Occupation: _____

Emergency Contact: Name: _____ Relationship: _____ Telephone: _____

Family Doctor: _____ Family Doctor Clinic Name or Address: _____

Medical Oncologist: _____ Radiation Oncologist: _____ _

Surgeon: _____ Other(s) (speciality): _____

Height: _____ Weight: _____

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 OICC? _____

What is your main reason for visiting the Ottawa Integrative Cancer Centre?

_____

_____

Cancer Specific Information

☐ Please check here if cancer is not the reason for your visit to the OICC.

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 getting 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			
☐ 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

Other Health Information

Past Hospitalizations

Year	Reason

Past Surgeries

Year	Type of surgery

Family health history please place an "X" in 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 circle 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, MS, 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?

_____

_____

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Drowsiness
No Nausea	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Nausea
No Lack of Appetite	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Lack of Appetite
No Shortness of Breath	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible _____

Patient's Name _____ Completed by (check one):

Date _____ Time _____

- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional
- ☐ Caregiver-assisted

Please review and sign the following three pages including: 1) the Consent for Care form; 2) Consent for Collection, Use and Disclosure of information; and 3) Consent to OICC Policies and Guidelines.
If you have any questions please speak with your OICC clinician.

OICC CONSENT FOR CARE FORM

The Ottawa Integrative Cancer Centre (OICC) offers complementary therapies to support people who have cancer, who want to reduce risk of cancer or cancer recurrence, and to improve general health. The OICC has a multidisciplinary team of health care providers trained in a variety of therapies. OICC clinicians assess the whole person, considering physical, mental, and spiritual aspects of health. Appointments may include history taking, physical examination, and treatments or treatment recommendations. Please note that intravenous treatments are never provided in initial visits.

Therapies and services offered at the OICC include:

- Acupuncture and TCM
- Cannabis consultations
- Counselling & Psychotherapy
- Craniosacral therapy
- Grief and death counseling
- Hypnotherapy & visualization
- Individual and group yoga
- Integrative medical care
- Intravenous therapies
- Massage therapy (RMT)
- Naturopathic medicine
- Nutritional counselling
- Physiotherapy
- Reflexology
- Reiki

It is important that you inform your clinician of any disease(s) or health conditions that you have, as well as any medications, supplements, and natural health products that you are taking. Please advise your health care provider of any allergies, and if you are pregnant, suspect you are pregnant, or are breastfeeding.

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

- Aggravation of pre-existing symptoms
- Development of new symptoms or side effects
- Allergic reactions
- Pain, bruising, or injury from venipuncture or acupuncture
- Emotional or psychological distress

Please read and understand the following:

- In the event of a medical emergency during evaluation or treatment, the OICC will take such measures as they consider to be in your best interest.
- The OICC cannot guarantee results of any treatment.
- The OICC is a teaching clinic and there may be students and/or other practitioners observing or participating in the session for learning purposes. You will always be asked, and have the right to decline student or other healthcare provider involvement.

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

Name (please print): _____

Signature: _____ Date: _____

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

The privacy and protection of your personal information is important to the Ottawa Integrative Cancer Centre (OICC).

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.

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 coordinate care between OICC practitioners;
- 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, 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.

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

- Only necessary information is collected about you;
- We only share your information with your consent;
- Our privacy protection protocols comply with Ontario's health privacy legislation (PHIPA);
- Storage, retention and destruction of your personal information complies with existing PHIPA legislation

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

I agree that the OICC can only collect, use and disclose personal information about myself as set out above in the information about the OICC's privacy policies.

Do you give the OICC permission to communicate with your other healthcare providers (e.g. GP, oncologist)? Y ☐ N ☐

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

Do you give the OICC permission to add you to our e-newsletter? Y ☐ N ☐

Name (please print):_____

Signature: _____ Date:_____

Please read and agree to follow these policies and guidelines. These are in place to ensure the best care possible for our patients, and to respect the patients, practitioners, and staff within the OICC.

- The reception desk is happy to serve your needs including scheduling and cancellations. Please call the front desk at 613-792-1222 ext 0. **Scheduling and health related concerns cannot be resolved by email.**
- A cancellation fee of **50% of the treatment cost** is applied to cancellations taking place within **24 hours** of the scheduled appointment. This includes OHIP-billing practitioners. IV therapy appointments may be cancelled without penalty up until 7:00am on the treatment day.
- 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.
- **Provincial health (e.g. OHIP, RAMQ) does not cover complementary medicine services (including but not limited to visits, lab tests, and natural health products)**. Some expenses may be eligible for reimbursement by private insurance plans; the OICC cannot accommodate third party billing. Service fees apply to all patients upon the date of their visit. Please review our Service and Fee schedule available online and at the reception desk. Those with financial difficulty are encouraged to ask about subsidized care.
- **Product dispensary:** to support the needs and convenience of our patients the OICC has a dispensary. Products are never required to be purchased from the OICC. The OICC has a conflict of interest policy and practitioners do not receive compensation for products purchased through the dispensary. Only products that have been recommended by an OICC practitioner to an active patient at the OICC may be purchased. The OICC does not stock a large inventory; please feel free to call reception if you are looking for a particular product.

Email Communication:

In order to receive email communication related to your care at the OICC, you must be aware of and accept the following:

- Treatment recommendations are not provided over email. Visit notes or follow up information may be emailed if requested or if discussed with your health care provider.
- 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, back-up copies may exist.
- If the patient's email requires or invites a response from the OICC and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up with the OICC. Although OICC clinicians will endeavor to read and respond promptly to patient emails, the OICC cannot guarantee that an 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.
- The patient is responsible for informing the OICC of any types of information the patient does not want sent by email. If you do not wish to send or receive email with the OICC, please inform an OICC staff member.
- The OICC will use reasonable means to protect the security and confidentiality of email information sent and received; however, because of the risks just outlined, the OICC 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 student interns.

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

Name (please print): _____

Patient Signature**:** _____ Date: _____