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

OICC CONSENT FOR CARE FORM

The Ottawa Integrative Cancer Centre (OICC) 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. OICC 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 OICC. 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.
- 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: _____

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

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.

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;
- 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

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PATIENT CONSENT

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 collect, use and disclose personal information about _____as set out above in the information about the OICC's privacy policies. (Patient Name)

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

Do you give the OICC permission to access your complete patient file at the Ottawa hospital? 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): _____ Date: _____

Signature: _____

Policies and Guidelines

At the OICC, our team of regulated health-care practitioners offers individualized, whole-person care and support in the treatment and prevention of cancer and cancer recurrence. The OICC welcomes patients seeking primary prevention; at initial diagnosis; during active conventional treatment including chemotherapy, radiation and surgery; prevention of recurrence; and in advanced cases.

Please visit our website at www.oicc.ca to learn more.

We provide a number of therapies for whole-person care, including:

- Naturopathic medicine
- Medical care
- Physiotherapy
- Acupuncture & TCM
- Nutritional Counseling
- Individual and group Yoga
- Counseling/Psychotherapy
- Reflexology
- Intravenous Therapies
- Massage therapy (RMT)
- Craniosacral therapy
- Conscious living coaching
- Hypnotherapy
- Reiki
- Family Therapy

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

- The reception desk is happy to serve your needs. In order to ensure the best service, please call the front desk at 613-792-1222. **Scheduling and health related concerns cannot be resolved by email.** All patients will have access to a care coordinator whose role is to guide and facilitate their treatment with the OICC. Care Coordinators can be contacted through the reception desk.

- A cancellation fee of **50% of the treatment cost** is applied to all 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 8 am 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.

- 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 OICC practitioners you imply consent for all your OICC 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 OICC 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 subsidization.

- The OICC 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.

See over

Policies and Guidelines

- The OICC 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 OICC may communicate directly with your oncologist, surgeon, or other health care providers to inform and collaborate regarding your care. OICC 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 OICC, 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 OICC 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 OICC of any types of information the patient does not want sent by email.

- 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.

- Although OICC clinicians will endeavor to read and respond promptly to patient emails, the OICC 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.

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: _____