# please read first

sunrise
HEALTH SERVICES

Dear New Client,

Thank you for the confidence and commitment you are demonstrating through your decision to pursue Naturopathic Health Care at our clinic. Congratulations for taking a step towards better health. You have the option to feel better, live healthier, and look and feel younger.

We commit to maintaining the highest professional ethics, competence and personal integrity at Sunrise Health Services. We also commit to helping you achieve your health goals through education, consultation and laboratory testing.

Your careful consideration of each of the enclosed questionnaires will enhance our efficiency and will provide for more effective use of your scheduled consultation time.

Please read and complete each form to the best of your ability. Note, you will have to get started on the Food Diary promptly as this requires time and careful attention (being sure to reflect your usual dietary habits.) If you feel that we have overlooked anything pertaining to your health, please add it to the package.

If you need further clarification, feel free to call us at the office 519.271.0763.

**Important** : Please bring completed forms to your initial consultation along with any supplements and medications you are currently taking. If the appointment is for a child under the age of 18 years old, please ensure a parent or legal guardian signs all consent forms.

Thank you for your time. We look forward to helping you achieve your health goals.

**Katherine Ackland** B.Kin., N.D.
**Courtney DeBoeck** BSc, N.D.
**Holly Johnson** BSc, N.D.

**CHOOSE TO LIVE A HEALTHY AND FULL LIFE EVERYDAY!**

# office policies

sunrise
HEALTH SERVICES

To facilitate the efficiency of our office and to ensure that you will derive maximum benefit from the care offered, we have established the following office policies:

1. Full payment is to be made at the time of your visit. We accept Cash, Cheque, Debit, Visa or Mastercard.

2. We respectfully request a **minimum of 2 business days** notice in the event that you cannot keep your appointment so that someone else on our waiting list could be accommodated. **Otherwise we would have to bill you for 50% of your missed appointment fee.** We understand that there are unforeseen events and circumstances, and these will of course be taken into consideration. Our answering machine is available outside of business hours to take messages.

3. With the number of clients we thoroughly interview, assess and treat, timing is crucial. For the respect and convenience of our clients and for the efficient operation of our clinic, we endeavour to keep scheduled appointments on time. However complications and emergencies do arise and in these circumstances, we appreciate your patience and understanding. You also will receive the devoted time and care of your doctor. **Please note that when you arrive late for your appointment, only the balance of the time that was booked for you can be used**.

4. We reserve the right to discharge any case where:

   • the Naturopath feels that the case is beyond the scope of practice of this clinic.

   • the Client refuses to co-operate with the recommendations mutually agreed upon.

5. We are required by our licensing board to perform a physical examination on each new client. This will be adhered to unless a full report is sent by the referring practitioner and that report is accepted by this office.

6. Telephone and e-mail consultations provide a professional service and as such will be subject to a fee on the discretion of the attending Naturopathic Doctor.

**Katherine Ackland** B.Kin., N.D.
**Courtney DeBoeck** BSc, N.D.
**Holly Johnston** BSc, N.D.

# pediatric intake form

Date: Name:

Mother's name: Father's Name:

Age: Grade: Date of Birth:

Sibling name(s) & age(s): Gender at birth: ○ M ○ F

Address: Preferred pronoun:

City: Postal code:

Home phone: Work phone:

Cell phone: E-mail address:

Referred by:

Child's Doctor: Phone:

Child's Specialist: Phone:

Main concern:

Describe carefully any factors that you suspect may have played a role in its onset and perpetuation:

What are the most significant measures which you have taken to-date, to improve your child's state of health?

Is his / her health currently: ○ Getting better ○ Getting worse ○ Staying the same

Current diagnosed health conditions:

## PREGNANCY & INFANCY

Birth weight: Born: ○ on time ○ early ○ late

If born early or late, by how many weeks?

Was the birth natural (ie. without medical intervention such as forceps, epidural, C-section...)? Please explain in detail:

Complications of mother and / or infant:

During pregnancy:

During labour / delivery:

After birth:

Developmental landmarks:

○ Delayed ○ Slower ○ Average ○ Faster ○ Accelerated

Additional comments and explanations:

## NUTRITION

| | | | | |
|---|---|---|---|---|
| Breastfed | ○ Yes | ○ No | How many months? | |
| Formula fed | ○ Yes | ○ No | How many months? | |
| Colicky baby | ○ Yes | ○ No | Until what age? | |
| First foods: | 1. | | at | months |
| | 2. | | at | months |
| | 3. | | at | months |

## VACCINATIONS

○ Yes ○ No Any illness associated with them?

## ALLERGY SHOTS

○ Yes ○ No For what?

Have you ever suspected or has your child ever had worms or parasites? ○ Yes ○ No

Does your child have any allergies to foods, drugs, inhalants? ○ Yes ○ No

If yes, please explain to what and how he / she reacts:

## PRESENT MEDICATIONS / SUPPLEMENTS:

| | | |
|---|---|---|
| 1: | dosage: | for what? |
| 2: | dosage: | for what? |
| 3: | dosage: | for what? |
| 4: | dosage: | for what? |

## DENTAL FACTORS

Does your child have any mercury fillings (silver)? ○ Y ○ N If yes, how many? _____

Do your child have any composite fillings (plastics)? ○ Y ○ N If yes, how many? _____

Did your child have mercury fillings in his / her baby teeth that have fallen out? ○ Y ○ N

Does or has your child ever been diagnosed with oral thrush? ○ Y ○ N

Has your child had an abcessed tooth? ○ Y ○ N

Are there any dental issues to be aware of in your child? ○ Y ○ N

If yes, describe _____

_____

## HOUSEHOLD FACTORS

Does mom or dad work in what you would consider a toxic work environment? ○ Y ○ N

If yes, describe _____

_____

Are there any smokers in the home? ○ Y ○ N

If yes, do they smoke inside the home or car? ○ Y ○ N

Do you have wireless technology in your home? ○ Y ○ N

If yes, do you have EMF protective devices installed? ○ Y ○ N What types? _____

Do your child use a cell phone, or handheld wireless device? ○ Y ○ N

If yes, does it have an EMF protective device on it? ○ Y ○ N

Does your child use wireless gaming devices? ○ Y ○ N

Does the school your child attends have wireless technology? ○ Y ○ N

Do you use conventional cleaning products & detergents? ○ Y ○ N

Do you use organic cleaning products and detergents? ○ Y ○ N

Do you have vinyl shower curtains in your bathrooms? ○ Y ○ N

Do you have wall to wall carpeting in your house? ○ Y ○ N

If yes, is it less than 2 years old? ○ Y ○ N

What is the age of your home? ____ years old

If your home was built before 1973, has it been checked for lead & asbestos? ○ Y ○ N

Do you have a moist / wet basement? ○ Y ○ N

Is there mold in your basement, bathroom, kitchen etc.? ○ Y ○ N

Do you live within 1/4 mile of hydroelectric power transformers or wires? ○ Y ○ N Now or in your past? _____

Do you live within 1/4 mile of a garbage dump? ○ Y ○ N Now or in your past? _____

Do you have an air purification system in your house? ○ Y ○ N If yes, what type? _____

**LIFESTYLE FACTORS**

Does your child consume 4-6 glasses of water daily? ◯ Y ◯ N

Is the water your child consumes municipal water with fluoride? ◯ Y ◯ N

Does your child use fluoridated toothpaste? ◯ Y ◯ N

Is the water your child consumes filtered? ◯ Y ◯ N What type of filtration? _____

Does your child consume water from plastic bottles? ◯ Y ◯ N

Does your child consume:

☐ pop ☐ sugar-added drinks ☐ energy drinks ☐ fruit cocktails ☐ chocolate milk

Does your child participate in regular exercise or sports? ◯ Y ◯ N

If yes, please describe: _____

_____

_____

How much screen time does your child have each day? (ipad, phones, smart boards, TV etc.):

◯ 1-2 hours ◯ 2-3 hours ◯ 3+ hours

# review of symptoms

Mark the applicable with: **C** = currently | **F** = frequently | **O** = occasionally | **S** = seldom | **P** = past | **N** = never

sunrise
HEALTH SERVICES

### ALLERGIES / INFECTION

____ asthma
____ cough (frequent acute)
____ cough (chronic)
____ wheezing
____ sinusitis
____ seasonal allergies
____ year round allergies
____ frequent colds
____ ear infections (acute)
____ ear infections (chronic)
____ hearing loss
____ bronchitis (acute)
____ bronchitis (chronic)
____ pneumonia
____ chronic fatigue
____ fatigue spells
____ nosebleeds
____ sore throats
____ high fevers
____ tonsillitis
____ runny nose
____ itchy eyes
____ rings under eyes
____ red / dry cheeks
____ post nasal drip
Med. alert tag ○ Y ○ N
For what?
other:

### DYSBIOSIS

____ thrush
____ diaper rash
____ vaginal irritation
____ colic / gas
other:

### CHILDHOOD INFECTIONS

____ chicken pox
____ red measles
____ German measles
____ croup
____ diptheria
____ mumps
____ scarlet fever
____ rheumatic fever
____ whooping cough
other:

### BOWELS

____ consipation
____ diarrhea
____ regular (1-2 b.m./day)
____ mucous
____ blood
____ green / yellow
other:

### DIGESTION

____ canker sores
____ diarrhea
____ constipation
____ stomach aches
____ vomiting spells
____ food allergies
____ bloating
____ abdominal cramps
____ hernia
other:

### SKIN

____ dry
____ chronic rash
____ eczema
____ psoriasis
____ hives
____ acne
____ bumps on back of arms
other:

### URINARY

____ incontinence
____ kidney stones
____ bladder infections
____ kidney infections
____ kidney malformations
____ bed wetting
other:

### SKELETAL

____ arthritis
____ flat feet
____ broken bones
____ spinal disorders
____ back pain
____ sciatica
____ neck pain
other:

### MIND & DISPOSITION

____ attention deficit
____ hyperactive
____ quick learner
____ insomnia
____ nervous / anxious
____ fearful
____ phobias
____ fearless
____ aggressive
____ angry, irritable
____ calm, relaxed
____ sad/depressed
____ sociable
____ anti-social
other:

### BLOOD / LYMPHATIC

____ anemia
____ easy bruising
____ easy bleeding
____ past transfusions
____ lymph node swelling
____ lymphatic disease
____ blood diseases
other:

### OTHER

____ heart condition
____ heart murmur
____ vision problems
____ headaches
____ head injuries
____ car accidents
other:

# medication history


Please record from the most recent to the most distant (past). Also, please indicate those that you are on presently, when you started them and how long you were on various medications in the past.

| Drug | Present | Past | Start Date | Stop Date | Reason for Medication and its Results |
|---|---|---|---|---|---|
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| Natural Medications / Supplements | | | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |
| | ○ | ○ | | | |

# food & activity report

NAME: WEEK NO:

Please take time to complete the following survey carefully and accurately. List in detail the quantity and the exact nature of all foods and beverages consumed (ie. frozen, canned, etc.). Please mention if the foods were raw or cooked. Be sure to list any condiments used (ie. mayonnaise, ketchup, margarine, relish, etc.).

sunrise
HEALTH SERVICES

| MEAL | DAY ONE | DAY TWO | DAY THREE | DAY FOUR |
|---|---|---|---|---|
| Morning meal & time | | | | |
| Snack | | | | |
| Noon meal & time | | | | |
| Snack | | | | |
| Evening Meal & time | | | | |
| Snack | | | | |
| Condiments (salt, sugar, herbs, spices, etc.) | | | | |
| Fats / Oils used | | | | |
| Water (cups per day) | | | | |
| Other beverages | | | | |
| Type of exercise | | | | |

Continued on reverse ›

# fee schedule

Effective February 15, 2024 | These services are not currently subsidized by OHIP | HST not included

### NATUROPATHIC CARE

| | |
|---|---|
| Initial Consultation – up to 1 hour | $230 |
| Naturopathic Consultation – up to 60 min. | $200 |
| Naturopathic Consultation – up to 45 min. | $165 |
| Naturopathic Consultation – up to 30 min. | $115 |
| Naturopathic Consultation – up to 15 min. | $75 |

### BIOENERGETICS | KIM SEBBEN

| | |
|---|---|
| BioEnergetic Initial Consultation – up to 60 min. | $155 |
| BioEnergetic Treatment (BIE)–up to 30 min. | $75 |
| Nutritional Consultation – up to 30 min. | $70 |
| BIA Scan – up to 15 min. | $30 |

### OTHER SERVICES

| | |
|---|---|
| E-mail Consults | $15 – $25 |
| Acupuncture with Doctor | $85 |
| Cranial Sacral Therapy – 30 min. | $70 |
| Forms or Comprehensive Reports | $15 – $120 |

### ADDITIONAL LAB SERVICES AVAILABLE

**Prices vary according to Service. Note that there will be a $15 applied to all blood collection services.**

Urinalysis | B12 Injection | Zinc Tally Test | Glucose | Cholesterol | Urine Chemstrip | Digestive Stool Analysis | Food Sensitivity Panel | Urinary Neurotransmitters | Various Conventional Blood Panels

**EAV Analysis** (Electro Acupuncture according to Dr. Voll) may be used during each visit. It is an elite form of Bio-Energetic Testing which uses the body's Meridian Systems to help determine the health, function & balance of the organs involved. The use of the equipment requires intensive post-graduate training for the Naturopathic Doctor to be able to properly give an assessment.

Fees for health services are due when services are rendered and may be paid by Cash or Cheque, Visa, Mastercard or Debit. There will be a $25 fee for NSF cheques.

I have read and fully understand the above description of the fee system and agree to honour it.

**Client or Guardian signature**

# patient consent form

**FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

sunrise
HEALTH SERVICES

Privacy of your personal information is an important part of our Clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this Clinic, SUNRISE HEALTH SERVICES acts as the Privacy Information Officer.

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 our Clinic 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
- our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopaths of Ontario (CONO)

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

Our Clinic understands the importance of protecting your- personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information.

This Clinic will collect, use and disclose information about you for the following purposes:

- to assess your health concerns
- to provide health care
- to advise you of treatment options
- to establish and maintain contact with you
- to send you newsletters and other information mailings
- to remind you of upcoming appointments
- to communicate with other treating health-care providers
- to allow us to efficiently follow-up for treatment, care and billing
- to complete claims for insurance purposes
- to comply with legal and regulatory requirements of our regulatory body, the College of Naturopaths of Ontario (CONO) acting under the authority of the Naturopathy Act
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this Clinic to comply with all regulatory requirements
- to comply generally with the law
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of the Patient Consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

**PATIENT CONSENT**

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

I agree that SUNRISE HEALTH SERVICES can collect, use and disclose personal information about

Patient's Name _____

as set out above in the information about the Clinic's privacy policies.

Signature _____ Print Name _____

Date _____ Witness _____

# e-mail and text communication consent form

I hereby acknowledge that I have requested the opportunity to communicate by e-mail and/or text communication. I understand that in this manner that I am exposing myself to certain risks. These risks include:

- The privacy and security of e-mail and/or text communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and retain e-mails and/or texts that pass through their systems.
- It is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the e-mail and/or text once it has been sent.
- E-mails and/or texts can introduce viruses into the operating system, and potentially damage or disrupt the computer and/or phone.
- E-mail and/or text are indelible. Even after the sender and recipient have deleted their copies of the e-mail and/or text, back-up copies may exist on a computer or in cyber space.
- If the patient's e-mail requires or invites a response from the Sunrise Health Services Team, 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 Sunrise Health Services Team received the e-mail and when they will respond.
- The patient is responsible for informing the Sunrise Health Services Team of any types of information the patient does not want sent by e-mail and/or text.
- The Sunrise Health Services Team will use reasonable means to protect the security and confidentiality of e-mail and/or text information sent and received; however, because of the risks just outlined, the Sunrise Health Services Team cannot guarantee the security and confidentiality of e-mail and/or text communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct by the Sunrise Health Services Team.

Although the Sunrise Health Services Team will endeavor to read and respond promptly to an e-mail from a patient, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Accordingly, patients should not use e-mail and/or text for medical emergencies or other time-sensitive matters. E-mail and/or text communication is not an appropriate substitute for clinical examinations. The Sunrise Health Services Team are not able to diagnose or give additional treatment advice via e-mail and/or text.

**PATIENT ACKNOWLEDGEMENT AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication by e-mail and/or text between the Sunrise Health Services Team and me and I consent to communication by e-mail and/or text in spite of these risks.

Patient Name _____ Date _____

Patient E-mail _____ Patient Cell Phone _____

Preferred method of communication: ○ Text ○ E-mail

Signature _____

(Patient or Guardian signature)