

please read first



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. The benefits of optimal health will be proportional to the effort and dedication you put into your daily choices. You have the option to feel better, live healthier, look and feel younger, and live longer. It is found that lasting improvement in one's health takes place in the presence of heightened focus, dedication and education.

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, laboratory testing, audio/visual aids and reading materials.

Your careful consideration of each of the enclosed questionnaires will enhance our efficiency, improve our accuracy 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 Diet Survey promptly** as this requires time and careful attention (being sure to reflect your usual dietary habits). Many find the completion of these forms a valuable process in itself. 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**. Please drop off your completed forms to the office, or at the very least have them filled out and bring them to your initial consultation.

Important : Please bring any supplements & medications you are currently taking with you to your appointment.

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 Johnston BSc, N.D.

CHOOSE TO LIVE A HEALTHY AND FULL LIFE EVERYDAY!



office policies

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.

patient intake form



Date: _____ Name: _____

Age: _____ Date of Birth: _____

Address: _____

City: _____ Postal code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail address: _____

Height: _____ Weight: _____ Occupation: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Doctor's name: _____ 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 state of health?

Is your health currently: Getting better Getting worse Staying the same

What seems to make it better? _____

What seems to make it worse? _____

Secondary concern(s): _____

Have you consulted a medical doctor regarding the aforementioned condition(s)? Please explain his/her diagnosis, therapy and results:

Have you attended a Doctor of Naturopathic Medicine before?

Y N Who? _____

Have you attended a Doctor of Chiropractic Medicine before?

Y N Who? _____

Are you currently working with a professional counsellor, psychologist or psychiatrist etc? Y N

Have you been counselled in the past? Y N

If you have been counselled in the past, please explain:

Please list the 3 most stressful events in your life (past or present):

Please list any allergies, the age and date when they began, and the symptoms they cause:

Drug(s):

what:	when:	symptoms:
what:	when:	symptoms:
what:	when:	symptoms:

Food(s)

what:	when:	symptoms:
what:	when:	symptoms:
what:	when:	symptoms:

Environmental:

what:	when:	symptoms:
what:	when:	symptoms:
what:	when:	symptoms:

Explain any treatments you have received for any of the aforementioned allergies and their results:

Family History: please indicate if there is any history of the following conditions in your family:

- heart disease diabetes asthma osteoarthritis kidney disease
 multiple sclerosis alcoholism drug abuse allergies rheumatoid arthritis
 psoriasis eczema mental illness ankylosing spondylitis
 other autoimmune disorders - type:
 cancer - what type(s):

Other conditions in your family:

lifestyle factors



How many hours of sleep do you get a night?

Is it restful?

If less than 7-8 hours of sleep per night, what is keeping you from sleep?

Do you use medications or alcohol to sleep? Y N

Do you take a multivitamin-mineral daily? Y N

Do you consume 6-8 glasses of water daily? Y N

If yes, is it purified water? Y N

Do you eat red meat? Y N

Do you fry or BBQ meat more than 3 times a week? Y N

Do you consume processed or preserved meats? Y N

Do you eat vegetables every day? Y N

Do you consume artificial sweeteners? Y N

Have you ever conducted a detoxification program? Y N

Do you fast for medical or religious reasons? Y N

Have you ever smoked? Y N

Do you presently smoke? Y N

Do you drink alcohol? Y N

Have you ever been an alcoholic? Y N

If yes, please put details on medication history form.

What type of filtration?

If yes, how many times per week?

If yes, how often?

If yes, how many servings daily?

What sources do you consume?

If yes, what type?

If yes, what types?

If yes, how long?

If yes, how much?

If yes, how often and how much?

How long?

What exercise or physical activities do you take part in?

Do you know your BMI (body mass index) number? A BMI number above 25 increases your risk of cancers & diabetes substantially. If you don't know your number your doctor can calculate it or you can Google and calculate it. My BMI number is: _____

OCCUPATIONAL FACTORS:

Please list any current or past jobs/hobbies that may involve exposures to toxic compounds like: solvents, disinfectants, antiseptics, chemicals, pesticides, herbicides, heavy metals, paints, polyvinyl chlorides etc.

household factors



Do you have wireless technology in your home? Y N

If yes, do you have EMF protective devices installed? Y N

What types? _____

Do you use a cell phone, portable phone or handheld wireless device? 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? _____

DENTAL FACTORS

Do you have any root canals? Y N

If yes, how many? _____

Do you have any crowns? Y N

If yes, how many? _____

Do you have any bridge work? Y N

Do you have any mercury amalgams (silver fillings)? Y N

Do you have any composite fillings (plastics)? Y N

Have you had old mercury fillings removed or replaced? Y N

- By a conventional dentist
- By a biological dentist

Do you presently have any teeth or gum infections? Y N

If yes, describe _____

Do you or have you ever been diagnosed with gum disease? Y N

Do you or have you ever been diagnosed with oral thrush? Y N

Do you have any dental issues you would like to discuss? Y N

If yes, describe _____

review of symptoms



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

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: _____

URINARY

- incontinence
- kidney stones
- bladder infections
- kidney infections
- kidney malformations
- bed wetting

other: _____

DIGESTION

- canker sores
- diarrhea
- constipation
- stomach aches
- vomiting spells
- food allergies
- gas
- bloating
- abdominal cramps
- colic
- hernia

other: _____

SKIN

- dry
- chronic rash
- eczema
- psoriasis
- hives
- diaper rash
- acne
- bumps on back of arms

other: _____

DYSBIOSIS

- jock itch
- thrush
- diaper rash
- vaginal irritation or discharge
- colic / gas
- athletes foot
- craves sugar

other: _____

SKELETAL

- arthritis
- flat feet
- broken bones
- spinal disorders
- back pain
- sciatica
- neck pain
- herniated discs

other: _____

MIND & DISPOSITION

- dyslexia
- attention deficit
- hyperactive
- quick learner
- mentally challenged
- slow learner
- insomnia
- nervous / anxious
- timid
- fearful

- phobias
- fearless
- aggressive
- angry, irritable
- violent
- calm, relaxed
- sad/depressed
- happy
- sociable
- anti-social

other: _____

CARDIAC

- heart condition
- heart murmur
- hypertension

other: _____

OTHER

- vision problems
- headaches
- head injuries
- eating disorders

explain: _____

- vehicle accident(s)

how many? _____

when? _____

other: _____

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

GASTROINTESTINAL

- ___ food allergies
- ___ heart burn / gerd
- ___ hernia
- ___ nausea
- ___ vomiting
- ___ excessive belching
- ___ excessive passing gas
- ___ bloating
- ___ jaundice
- ___ liver disease
- ___ gallbladder disease
- ___ gallstones
- ___ ulcer
- ___ indigestion
- number of bowel movements / day ___
- ___ loose stools
- ___ diarrhea
- ___ hard stools
- ___ mucous in stool
- ___ blood in stool
- ___ black, tarry stool
- ___ yellow/pale stool
- ___ greenish stool
- ___ irritable bowel syndrome
- ___ colitis
- ___ crohn's disease
- ___ rectal bleeding
- ___ hemorrhoids
- ___ anal fissures
- ___ anal prolapse
- ___ abdominal pain
- ___ stomach pain
- ___ pancreas disease

___ bowel polyps

other: _____

BLOOD / LYMPHATIC

- ___ anemia
- ___ easy bruising
- ___ easy bleeding
- ___ past transfusions
- ___ lymph node swelling
- ___ lymphatic disease
- ___ blood diseases

other: _____

EMOTIONAL

- ___ depression
- ___ anxiety
- ___ mood swings
- ___ nervousness
- ___ panic attacks
- ___ phobias
- ___ irritable
- ___ angry
- ___ insomnia
- ___ worrier
- ___ S.A.D.

MALES ONLY

- ___ prostate problems
- ___ prostate surgery
- ___ hernia
- ___ testicular masses
- ___ testicular pain
- ___ discharge or sores
- ___ venereal disease
- ___ sexual difficulties

other: _____

FEMALES ONLY

- have your periods ceased?
 Y N
- hysterectomy Y N
- why? _____
- birth control Y N
type: _____
- age of menses ___ years
- average length of cycle ___
- number of days of menstruation ___
- ___ irregular cycles
- ___ bleeding between periods
- ___ PMS
symptoms: _____

- ___ painful menses
- ___ excessive flow
- ___ fibroids
- ___ ovarian cysts
- ___ cervical dysplasia
- ___ cervical / uterine cancer
- ___ ovarian cancer
- ___ vaginal discharge
- ___ vaginal dryness
- ___ venereal disease
- ___ pain on intercourse
- ___ hot flashes
- ___ night sweats
- ___ estrogen replacement
type: _____

- number of pregnancies ___
- number of miscarriages ___
- number of abortions ___
- ___ difficulty conceiving
- ___ breast lumps
- ___ breast tenderness
- ___ breast implants
- ___ nipple discharge
- ___ sexual difficulties

last PAP _____

other: _____

LIFESTYLE

- number of coffees / day ___
- number of teas / day ___
 herbal
 regular
- number of colas / day ___
- ___ relaxation exercises
- ___ recreational drugs
type: _____
frequency: _____

personal medical history



Blood type: A B AB O

List hospitalizations & surgeries (date & why):

List X-rays, CAT scans, EKOs, MRIs, etc. (date & why):

List any past traumas or accidents with the date of occurrence:

CHILDHOOD HISTORY

Were you breastfed? Y N For how long? _____

Were you bottle fed? Y N For how long? _____

Are you immunized? Y N If yes, any reactions? _____

travel vaccines flu shots non-mandated vaccines

Was your birth process natural? Y N

Did you experience forceps C-section? epidural anesthesia

Were you a colicky baby? Y N Until what age? _____

Which childhood illnesses did you have?

Polio chicken pox German measles mumps scarlet fever red measles

rashes rheumatic fever whooping cough worms ear infections allergies

frequent colds eczema diphtheria croup bronchitis/pneumonia

OTHER HISTORY

Have you ever had a tick bite? Y N

Have you ever suspected or have had parasites? Y N

Have you ever had Mono (Epstein Barr syndrome)? Y N

Have you ever been diagnosed with: heart troubles diabetes thyroid disease
 circulation problems auto immune disease arthritis cancer AIDS

What do you feel is your weakest organ system and why?

How many times per year do you have a cold, sinusitis, sore throat, bronchitis, or flu?

How long do they usually last?

Do you take any medication for the above? Y N

If yes, what do you take?

This information is strictly confidential between you and the Doctor and your accurate responses are vital to effective health care at this office. Please go back over your responses and consider their accuracy. Thank you!

dysbiosis questionnaire



HISTORY

POINT SCORE

To answer 'yes' to a question, circle the point score on the right.

1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for skin, acne or anything else for 1 month (or longer)? 25
2. Have you, at any time in your life, taken other broad spectrum antibiotics for respiratory, urinary or other infections 4 or more times in a 1 year period? 20
3. Have you taken a broad spectrum antibiotic drug – even a single course? 6
4. Have you at any time in your life been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs? 25
5. Have you taken birth control pills ...
 - for more than 5 Years 25
 - for more than 2 Years 15
 - for 6 month to 2 Years 8
6. Have you been pregnant ...
 - 2 or more times 5
 - 1 time 3
7. Have you taken prednisone, Decadron or other cortisone type drugs ...
 - for more than 6 months 25
 - for more than 2 weeks 15
 - for 2 weeks or less 6
8. Does exposure to perfumes, insecticides, fabric shop odours and other chemicals provoke ...
 - moderate to severe symptoms 20
 - mild symptoms 5
 - list symptoms: _____
9. Are your symptoms worse on damp muggy days or in mouldy places? 20
 - list symptoms: _____
10. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungus infections of the skin or nails?
 - Have such infections been ...
 - severe or persistent 20
 - mild to moderate 10
11. Have you ever had parasitic infection, dysentery or unexplained episode of prolonged diarrhea, & intestinal distress? . 15
12. Do you have or have you ever had an ulcer, colitis, Crohn's disease or diverticulitis? 35

Total Score: _____

diet & 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.).

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				

MEAL	DAY FIVE	DAY SIX	DAY SEVEN	DAY EIGHT
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				

fee schedule

Effective September 1, 2016 | These services are not currently subsidized by OHIP | HST not included



NATUROPATHIC CARE

Initial Consultation – 1 hour	\$150 – \$160
Naturopathic Consultation – 30 min.	\$75 – \$80
Naturopathic Consultation – 45 min.	\$115
Naturopathic Consultation – 15 min.	\$50

PHYSIOTHERAPY

Initial Assessment – 1 hour	\$89
Subsequent Treatment – 45 min.	\$73
Subsequent Treatment – 30 min.	\$58

HOLISTIC NUTRITION & BIOENERGETICS

BioEnergetic Initial Assessment & Technique – 1 hour.	\$148
BioEnergetic Technique – 30 min.	\$60
Nutritional Consultation – 30 min.	\$60
BIA Scan – 15 min.	\$20

REGISTERED MASSAGE THERAPY

30 minute treatment	\$50
45 minute treatment	\$70
60 minute treatment	\$80
90 minute treatment	\$110

OTHER SERVICES

Phone Consult – 15 min.	\$25 (\$45 – 30 minutes)
E-mail Consults	\$15 – \$25
Acupuncture with Doctor	\$45
Cranial Sacral Therapy – 30 min.	\$50
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 | Hair Analysis | Glucose | Cholesterol | Urine Chemstrip | Allergy Spot Test | Saliva Hormone Testing | Digestive Stool Analysis | 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



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 Board of Directors of Drugless Therapy – Naturopathy

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 Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners 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 _____