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. 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

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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.

patient intake form

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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

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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	If yes, please put details on medication history form.
Do you consume 6-8 glasses of water daily?	○ Y	○ N	
If yes, is it purified water?	○ Y	○ N	What type of filtration?
Do you eat red meat?	○ Y	○ N	If yes, how many times per week?
Do you fry or BBQ meat more than 3 times a week?	○ Y	○ N	
Do you consume processed or preserved meats?	○ Y	○ N	If yes, how often?
Do you eat vegetables every day?	○ Y	○ N	If yes, how many servings daily?
Do you consume artificial sweeteners?	○ Y	○ N	What sources do you consume?
Have you ever conducted a detoxification program?	○ Y	○ N	If yes, what type?
Do you fast for medical or religious reasons?	○ Y	○ N	If yes, what types?
Have you ever smoked?	○ Y	○ N	If yes, how long?
Do you presently smoke?	○ Y	○ N	If yes, how much?
Do you drink alcohol?	○ Y	○ N	If yes, how often and how much?
Have you ever been an alcoholic?	○ Y	○ N	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

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HEALTH SERVICES

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

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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: _____

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	○	○			
	○	○			
	○	○			
	○	○			
	○	○			
	○	○			
	○	○			
	○	○			
	○	○			
	○	○			
	○	○			

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 ○ diptheria ○ croup ○ bronchitis/pneumonia

OTHER HISTORY

Have.you ever had a tic 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 may 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

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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.).

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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 ›

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 January 1, 2018 | These services are not currently subsidized by OHIP | HST not included

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NATUROPATHIC CARE

Initial Consultation – 1 hour	$160 – $175
Naturopathic Consultation – 30 min.	$80 – $89
Naturopathic Consultation – 45 min.	$115 – $130
Naturopathic Consultation – 15 min.	$50

PHYSIOTHERAPY

Initial Assessment – 1 hour	$90
Subsequent Treatment – 45 min.	$75
Subsequent Treatment – 30 min.	$59

HOLISTIC NUTRITION & BIOENERGETICS

BioEnergetic Initial Assessment & Technique – 1 hour	$148
BioEnergetic Technique – 30 min.	$65
Nutritional Consultation – 30 min.	$65
BIA Scan – 15 min.	$20

REGISTERED MASSAGE THERAPY

30 minute treatment	$52
45 minute treatment	$72
60 minute treatment	$82
90 minute treatment	$112

OTHER SERVICES

Phone Consult – 15 min.	$25 ($45 – 30 minutes)
E-mail Consults	$15 – $25
Acupuncture with Doctor	$50
Cranial Sacral Therapy – 30 min.	$55
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

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, tile 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 _____