

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.

pediatric intake form



Date: _____ Name: _____

Mother's name: _____ Father's Name: _____

Age: _____ Grade: _____ Date of Birth: _____

Sibling name(s) & age(s): _____

Address: _____

City: _____ Postal code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail address: _____

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

Secondary concern(s): _____

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?

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:

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: _____

DYSBIOSIS

- thrush
- diaper rash
- vaginal irritation
- colic / gas

other: _____

CHILDHOOD INFECTIONS

- chicken pox
- red measles
- German measles
- croup
- diphtheria
- mumps
- scarlet fever
- rheumatic fever
- whooping cough

other: _____

BOWELS

- constipation
- 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

- dyslexia
- attention deficit
- hyperactive
- quick learner
- mentally challenged
- slow learner

- insomnia
 - nervous / anxious
 - fearful
 - phobias
 - fearless
 - aggressive
 - angry, irritable
 - violent
 - calm, relaxed
 - sad/depressed
 - happy
 - 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: _____

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 _____