SUNMI Naturopathic Health
Healing through Nature

New patient intake form-Child

Dear New Patient,

Welcome to the Sunmi Naturopathic Health. You have just taken an important step towards optimizing your health.

Before your first visit, please complete an intake form and bring it all with you to your first appointment so that I can better understand your health history and health goals. Please complete the package as thoroughly as possible. If you have any questions regarding the form, leave the section blank and we will go over it at your appointment. All information is strictly confidential.

The first visit includes an in-depth naturopathic assessment of your health concerns, medical history, and health goals which will last for about1 hours. I will review your completed health questionnaire with you, ask detailed questions relevant to your health concerns, run a screening urine test and perform a physical exam if time permits. I may recommend certain diagnostic tests in order to gain a better understanding of your health status. In most cases, a second follow-up visit will be scheduled. This visit will be used to complete the physical exam, to discuss the results of your test(s) and to implement a treatment plan. Your treatment plan may include any combination of dietary recommendations, lifestyle changes, herbs, Chinese medicine, acupuncture, or nutritional supplements. Subsequent visits will be booked, as necessary, to review your progress and make appropriate changes to your program. Follow-up visits can be scheduled anywhere from 30 to 45 minutes.

It is essential to remember that you need to be patient with your body.
Some of our patients have spent many years with chronic medical problems unsolved by conventional medicine. Some are currently receiving positive and necessary treatment from one or more medical doctors or other health-care providers. Some are simply not feeling well and want to improve their general health. Whichever scenario applies to you, it is important to realize that it takes time to feel better when using naturopathic medicine. We usually tell patients to expect to visit us at least four (4) times and to expect to wait approximately two (2) months before noticing significant changes. Some patients of notice changes much sooner, but as a patient, we ask you to be patient! We are confident that with the necessary information and a consistent effort from you, we can help you; but it may take some time.

Any supplements prescribed at your visits can be purchased from the clinic, a health food store or a medical supply company of your choice.

Please note that payment is due at the end of your visit. Be sure to check with your extended health care plan to determine if the appointment cost will be covered. If you are unable to make a scheduled appointment, please provide at least 24 hours notice, so that time can be made available to another patient. Missed appointments without notice will be subject to a charge the full fee.

If at any time you have questions or concerns regarding your treatment, please feel free to voice them during your visits, or contact me at the office at 613.501.4312. I look forward to working with you to help you enjoy long lasting improvements in your health.

Best in health,

Dr. Sunmi Cha, BScH, ND
Naturopathic Doctor

SUNMI CHA, ND
NATUROPATHIC DOCTOR
1085 Foley, Ottawa, ON K1G 2R4
Email: sunmichand@gmail.com Tel1. (613) 501.4312 Fax. (613) 903-4945 www.sunmihealth.com

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Professional Fees for Naturopathic Services

The following fee scale is based on the consultation, as well as the time needed to research and design an individualized treatment plan for you.

CHILD

In-office consults Fees

Type of Visit	Length	Fees
Initial Consult-Child Thorough health history taken Urinalysis Physical exam Lab tests, if required (extra cost)	60 minutes	$200
2nd Visit-Child General screening physical exam Initiation of treatment plan Nutritional consultation	15 minutes	$65
	30 minutes	$100
	60 minutes	$200
Follow up Visit Monitoring of treatment plan	15 minutes	$65
	30 minutes	$100
	60 minutes	$200
Acupuncture / Cupping Must follow an initial consultation	45 minutes	$100
Acute Visit (colds/flus)	15 minutes	$65
B12 Shot Only	5 minutes	$40
Phone/Skype consultations Must follow an initial consultation in person	15 minutes	$65
	30 minutes	$100

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Child Intake Form

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Your time and thoughtfulness in completing this overview will aid with the assessment of your child's health needs.
PLEASE COMPLETE AND BRING THIS FORM **WITH YOU** TO YOUR CHILD'S FIRST APPOINTMENT

Patient name _____ Date of birth _____ Age:_____ Sex: Male Female
Who is filling out this form? :_____ Relationship to child: _____

Contacts (in order of preference):
1. Name:_____ Email:_____ Relationship to child: _____
Address: _____ City: _____ Prov: _____ Postal: _____
Home telephone: _____ Work: _____ Mobile: _____

2. Alternate contact:_____ Relation: _____ Telephone:_____
With whom does the child live? _____

OTHER HEALTH CARE PROVIDERS:
1. Family physician: _____ Telephone: _____ Fax:_____
Address: _____ City: _____ Prov: _____ Postal:_____
2. Other health provider: _____ Profession:_____ Phone:_____
3. Other health provider: _____ Profession:_____ Phone:_____

How did you hear about Dr. Sunmi Cha, ND: Internet Search / Referral by Doctor
(specify who):_____ Other (please specify): _____

MEDICAL HISTORY:

Your child's current health and well-being are: ☐Excellent ☐Very Good ☐Good ☐Fair ☐Not good ☐Poor

Health concerns (please list in order of importance):
1. _____ Date of onset:_____
2. _____ Date of onset:_____
3. _____ Date of onset:_____
4. _____ Date of onset:_____
5. _____ Date of onset:_____

Please list any serious conditions, illnesses or injuries, and any hospitalizations, along with approximate dates:
1. _____ Date of onset:_____
2. _____ Date of onset:_____
3. _____ Date of onset:_____
4. _____ Date of onset:_____
5. _____ Date of onset:_____

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)
☐n☐m☐a☐s Rubella (German measles) ☐n☐m☐a☐s Roseola ☐n☐m☐a☐s Impetigo

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☐n☐m☐a☐s Rubeola (English measles) ☐n☐m☐a☐s Scarlet fever ☐n☐m☐a☐s Mononucleosis
☐n☐m☐a☐s Chicken pox ☐n☐m☐a☐s Whooping cough ☐n☐m☐a☐s Ear infections
☐n☐m☐a☐s Mumps ☐n☐m☐a☐s Strep throat

Immunizations your child has had:

☐DPT (diphtheria, pertussis, tetanus) ☐Haemophilus influenza B ☐Hepatitis B
☐Tetanus booster; when? _____ ☐Flu ☐Hepatitis A
☐MMR (measles, mumps, rubella) ☐Polio ☐Smallpox
Other _____

Please indicate if any caused adverse reactions:

_____

Does your child have any allergies (medicines, environmental, etc.)?

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Medication/Supplement	Dose/ day	How long?	Reason
1.			
2.			
3.			
4.			
5.			

How many courses of antibiotics has your child been treated with? _____

What screening tests has your child had (blood, hearing, vision, etc.)?

Has your child had any of the following? If so, what was the reason and when was the most recent date?

- Blood work for: _____ Date: _____
- X - rays or imaging for: _____ Date: _____
- Eye Examination for: _____ Date: _____
- Hearing tests for: _____ Date: _____

Trauma, surgery, hospitalization, accident, and any complications.

_____
_____

FAMILY HISTORY

	Yes (v)	Relation Please circle	Dates Resolved		Yes (v)	Relation Please circle	Dates Resolved
Alcoholism/ drug addiction		Self F M S G C	Past/Current	High blood pressure		Self F M S G C	Past/Current

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Allergies		Self F M S G C	Past/Current	Heart Disease		Self F M S G C	Past/Current
Anemia		Self F M S G C	Past/Current	Hepatitis		Self F M S G C	Past/Current
Asthma		Self F M S G C	Past/Current	Headaches		Self F M S G C	Past/Current
Cancer		Self F M S G C	Past/Current	Kidney disease		Self F M S G C	Past/Current
Diabetes		Self F M S G C	Past/Current	Tuberculosis		Self F M S G C	Past/Current
Eczema		Self F M S G C	Past/Current	Thyroid disorder		Self F M S G C	Past/Current
Epilepsy		Self F M S G C	Past Current	Others:		Self F M S G C	Past/Current
Depression/ other mental illness		Self F M S G C	Past Current	Others:		Self F M S G C	Past/Current

PRENATAL HEALTH

Please rate each parent's health at conception:

Mother: ☐Excellent ☐Very good ☐Good ☐Fair ☐Not good ☐Poor ☐Unknown

Father: ☐Excellent ☐Very good ☐Good ☐Fair ☐Not good ☐Poor ☐Unknown

Please rate the health of the mother during pregnancy

☐Excellent ☐Very good ☐Good ☐Fair ☐Not good ☐Poor ☐Unknown

Mother's age at child's birth? _____ **Did the mother receive prenatal medical care?** ☐Y ☐N ☐Unknown

How was the mother's diet during pregnancy?

☐Excellent ☐Very good ☐Good ☐Fair ☐Not good ☐Poor ☐Unknown

Did the mother experience any of the following during the pregnancy:

☐Bleeding ☐High blood pressure ☐Nausea ☐Vomiting ☐Diabetes ☐Thyroid problems
☐Physical or emotional trauma ☐Other_____

Did the mother use any of the following during the pregnancy?

☐Tobacco
☐Alcohol
☐Recreational drugs, please specify: _____
☐Prescription medications, please specify: _____
☐Over-the-counter medications, please specify: _____
☐Supplements, please specify: _____
☐Other, please specify: _____

BIRTH HISTORY

Length of pregnancy term: ☐Full_____ ☐Premature: _____ wks ☐Late: _____ wks
Length of labour: _____ **Weight at birth** _____
Any complications? _____
Was the birth: ☐Vaginally delivered ☐C-section ☐Induced
Please indicate if any of the following was required: ☐Epidural or anesthesia ☐Forceps ☐Vacuum
Did the child experience any of the following at or shortly after birth?
☐Jaundice ☐Rashes ☐Seizures ☐Birth injuries ☐Birth defects ☐Other _____

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DIET

How was your infant fed?

☐Breast fed. How long? _____ ☐Formula. Milk/Soy/Other: _____

☐Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

1) _____Age:_____ 4) _____Age:_____

2) _____Age:_____ 5) _____Age:_____

3) _____Age:_____ 6) _____Age:_____

6–12 months?

_____

_____

Favorite foods:

_____

Did your child ever experience colic? ☐Y ☐N How severe? ☐mild ☐moderate ☐severe

Does your child have any food allergies or intolerances? Please list.

_____

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

SLEEP

Please indicate if your child experience's any of the following sleep habits/behaviours/ issues:

☐Frequent nightmares ☐Sleep walking ☐Teeth grinding ☐Bed wetting ☐Other _____

HEALTH AND DEVELOPMENT

How was your child's health in the first year?

☐Excellent ☐Very good ☐Good ☐Fair ☐Not good ☐Poor ☐Unknown

At what age was your child able to: Sit up _____ Crawl _____ Stand _____ Walk _____ Talk _____

Please list any concerns about your child's mental or physical development:

_____

SOCIAL/PSYCHOLOGICAL

How would you describe your child's temperament? _____

Does your child currently attend daycare or school? _____

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Please list any learning disabilities or concerns with school performance:

_____

How would you describe your child's personality?

_____

Does your child enjoy playing with other children? _____
How much time each week is spent with friends and peers? _____
What are their activity preferences? How do they like to spend their time?

_____

What extracurricular activities is your child involved in?

_____

How much time is spent each day watching television and playing video games? _____
Is your child involved in any form of exercise? If so, what type of exercise and how often?

_____

ENVIRONMENT

Does anyone in the child's household smoke? ☐Y ☐N
Are there animals in the home? ☐Y ☐N
How is the child's home heated? ☐Natural Gas ☐Oil ☐Electric ☐Wood ☐Other _____
Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

_____

How would you describe the emotional climate of the child's home?

_____

Is there anything that you feel is important that has not been covered?

_____

Thank you for completing this form.

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INFORMED CONSENT TO TREATMENT OF MINOR

This is to acknowledge that I, _____, parent/legal guardian of _____, whose relationship to me is as a _____, have been informed and understand that:

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non - invasive treatments are generally used to stimulate the body's healing capacity. As part of your naturopathic treatment, a thorough case history, physical examinations and certain diagnostic testing may be performed.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include dietary modification, clinical nutrition, lifestyle counseling, botanical medicine, homeopathy, traditional Chinese medicine & acupuncture, hydrotherapy and physical medicine.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends dramatically on the individual and the extent of the illness. Some therapies must be used with caution in certain conditions or disease such as diabetes and/or heart/liver/kidney disease; therefore, it is very important that you inform your naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast - feeding

Some of the potential health risks that may arise with treatment by naturopathic medicine include, but are not limited to:

- Aggravation of pre - existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture or cupping
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injures from spinal manipulation.
- The potential for stroke is a concern in neck manipulation, but tests will be done to screen for this possibility. Clinical research has shown that stroke - like occurrences are rare – approximately 1 in 1.5 million manipulations.

I understand that my naturopathic doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below):

Herbal Dispensary & Naturopathic Medicines:

The naturopathic doctor may prescribe supplements that can be purchased from clinic or at other locations. I understand that I have a freedom to choose where I purchase the recommended products, but that certain professional product lines are only available through licensed Naturopathic Doctors. Most insurance companies do not cover supplements that are prescribed and dispensed by the naturopathic doctor.

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Confidentiality

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fees. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Cancelled and Missed Appointments

I acknowledge that I must give at least 24 hrs. cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, the full fee will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of Dr. Sunmi Cha.

In Case of Emergency

I understand that emergency medical services are not offered by Sunmi Cha, ND. In case of an emergency, I should dial 911, or proceed to the Emergency Department of the nearest hospital.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider; I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario; No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

The treatment and therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive from Sunmi Cha, ND and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, administrative fees as well as other applicable fees.

_____	_____
Patient Full Name (please print)	Naturopathic Doctor (ND License # 2839)
_____	_____
Signature of Patient or Guardian (if patient is under 18 yrs of age)	Date of Consent

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PRIVACY POLICY

The Privacy of your personal information is an important part of business practice with Sunmi Cha, while at the same time 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.

- Only necessary information is collected about you;
- Only with your consent is your information shared with others outside the clinic;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Sunmi Cha, ND's privacy policy conforms to privacy legislation and standards of the Board of Directors of Drugless Therapy – Naturopathy.

Personal information is collected in order to:

- Assess you health;
- Provide health care;
- Advise you of treatment options;
- Establish and maintain contact with you regarding appointments, invoicing and follow - up care;
- Send you pertinent information and mailings;
- Facilitate your insurance claims
- Allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale;
- Comply with the legal and regulatory requirements of the Drugless Practitioners Act.

By signing below, 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 Sunmi Cha, ND will use my personal information, and the steps that they are taking to protect my information. I agree that Sunmi Cha, ND can use and disclose personal information about _____ as set out above in the information Sunmi Cha's privacy policies. (Patient Name)

**Please sign and return this form to your Naturopathic Doctor on your first visit*

_____ _____

Signature Date

_____ _____

Witness Date

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Email Communication Consent Form

I hereby acknowledge that I have requested the opportunity to communicate by email. I understand that in communicating in this manner that I am exposing myself to certain risks. These risks include:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and retain emails 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 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 practitioner 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 practitioner of any types of information the patient does not want sent by email.

The practitioner will use reasonable means to protect the security and confidentiality of email information sent and received; however, because of the risks just outlined, the practitioner 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 practitioner.

Although the practitioner will endeavor to read and respond promptly to an email from a patient, the practitioner 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. Email communication is not an appropriate substitute for clinical examinations.

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication by email between the practitioner and me. I consent to communicating by email with practitioner in spite of these risks.

Patient Name _____

Patient Email _____

Signature _____ Date _____

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ACKNOWLEDGEMENT

TO: Sunmi Cha ND

FROM: Your name _____

RE: **CONSENT TO TREATMENT**

Your name_____

I hereby acknowledge that my naturopathic doctor has explained to me the nature of the naturopathic treatment I am to receive including the benefits of the treatment, any risks associated with the treatment and any medical alternatives. I hereby consent to the treatment as set out below.

I may withdraw my consent to this treatment at any time.

DATE: _____

SIGNATURE: _____

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