the naturopathic care centre

Please Read First

Dear New Patient,

Thank you for making an appointment with me to discuss and improve your health. I congratulate you on your decision to take steps toward improved well-being. In return, I commit to helping you achieve your health goals and to help you learn and understand what is going on in your system in order for us to work together to correct any imbalances that are presently causing your health challenges.

I would appreciate your careful consideration in answering the questions in the attached forms. By completing these forms with as much information as possible it will improve the accuracy of your assessment and allow us to have a more effective consultation. This reduces the need for extended consultation time and this subsequently saves you money and improves the care that I can provide for you.

Please read and complete the materials before your appointment. ***YOU WILL HAVE TO START YOUR DIET SURVEY PROMPTLY*** *as this requires a week of careful attention (while being sure to reflect your usual dietary habits). If you reach a question you do not know how to answer, simply leave it blank and we can talk about it in our first consultation.*

Please fill out forms to the best of your ability and bring completed forms with you to your initial consultation. If you have any recent medical test results that are relevant, please bring them along to your appointment. Also, please bring any vitamins or supplements you are taking currently.

Naturopathic medicine is an individualized approach to primary health care and is unique in its integrated approach to health. It is the art, science and practice of preventing, diagnosing and treating conditions of the human mind and body through the use of natural substances and non-invasive treatments. Naturopathic doctors are primary-care physicians who are trained at accredited medical colleges in a four-year full time program. Naturopathic doctors have extensive academic and clinical training with respect to the therapeutic use, contraindication, possible adverse reactions and toxicities of natural remedies.

Naturopathic doctors work with their patients to prevent and treat acute and chronic illness. I help patients restore health and establish optimal fitness by supporting the body's ability to heal through natural treatments and by treating the underlying cause of the illness rather than simply eliminating or suppressing symptoms. Treatments used in my practice include: clinical nutrition and supplementation, botanical medicine, acupuncture, homeopathy and lifestyle counselling. Treatments are selected based on the individual needs of each patient. If you have a particular interest in one or more of these treatment modalities please discuss it during your consultation.

In addition to being a Naturopathic Doctor, I am also a Registered Acupuncturist. If you are interested in exploring acupuncture as part of your treatment, please check your insurance, you may have additional separate coverage for acupuncture by a Registered Acupuncturist (R.Ac.). Acupuncture can qualify for insurance reimbursement through either naturopathic benefits or acupuncture benefits depending on your insurance plan. If you have R.Ac. coverage in addition to your naturopathic coverage, please notify us in your first visit so we can set up your files accordingly.

Thank you for your time in advance, and I look forward to working with you to achieve your optimum health.

Dr. Carrie Meszaros, B.Sc., N.D., R.Ac.
Naturopathic Doctor & Registered Acupuncturist

288 Wellington Street, Stratford, ON N5A 2L9 Telephone 519-271-2440 reception@carriemeszarosnd.ca

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2017 Fee Schedule and Office Policies for Dr. Carrie Meszaros, B.Sc., N.D., R.Ac.

** These services are not currently subsidized by OHIP. All naturopathic and acupuncture visits are exempt from HST.

Naturopathic Visits

Initial Consultation, adult patient (60 minutes)	$160
Initial Child Consultation, (child age 12 and under) (45-60 minutes)	$140
Second Visit (45 minutes)	$115
Extended Second Visit (60 minutes)	$135
Naturopathic Consultation (30 minutes)	$ 80
Naturopathic Consultation (45 minutes)	$110
Naturopathic Consultation (60 minutes)	$135
Naturopathic Review (less than 15 minutes)	$ 45
Naturopathic Re-Assessment (18 months since last appointment)	$130
Naturopathic Acupuncture Treatment (without consultation)	$ 65
Naturopathic Acupuncture with Consultation (30 minutes)	$ 80
Naturopathic Acupuncture with Consultation (45 minutes)	$110

Registered Acupuncture Visits

*Initial Acupuncture Consultation (non-naturopathic patient) (60 minutes)	$160
*Second Acupuncture Visit (for non-naturopathic patient) (45 minutes)	$115
Acupuncture Treatment (without consultation)	$ 65
Acupuncture with Consultation (30 minutes)	$ 80
Acupuncture with Consultation (45 minutes)	$110

***Patients that are currently Naturopathic Patients are exempt from the initial and second visit acupuncture assessments and will be booked instead for either a 30 or 45 minute Acupuncture consultation for their first acupuncture visit.**

Services and Fees

Cancelled Appointment - with less than 24 hours notice	$ 35
Missed Appointment - without notice	$ 50
Simple Doctor's Notes	$ 25
Prescription refills without corresponding office visit	$ 25
Comprehensive Medical Forms and Reports	fee based on complexity

Fees for health services and supplements are due when services are rendered and may be paid by cash, cheque, Visa, MasterCard or Debit. There is a $20 fee for NSF cheques.

We request a minimum of 24 hours notice in the event you cannot keep your appointment. Our answering machine is available during off hours to take any messages. Without minimum notice we will charge $35 for the missed appointment. If an appointment is missed without a cancellation call you will be charged $50. Please note that if you arrive late for your appointment, only the balance of time that had been booked for you can be used and you will be charged for the full visit length.

For the respect and convenience of our patients and for 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.

Clarification emails or short phone calls (5 minutes or less) about existing treatment plans or to update us about significant health changes are encouraged without an associated fee. This would include clarifying instructions, reporting any new side effects associated with current treatment plans or any changes in prescription medications. Telephone consultations and emails that require lengthy responses are professional services and may be subject to a fee. Telephone calls of more than 10 minutes with our Naturopathic Doctor will be billed as consultations. Prescription renewals without a corresponding office visit are subject to a $25 fee.

I have read and fully understood this fee schedule and office policies and I accept the terms outlined.

Patient's or guardian's signature _____ Dated _____

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Dr. Carrie Meszaros, N.D., R.Ac.

Naturopathic Patient Intake Form

Date: _____

Name: _____ Age: _____ Date of Birth: _____
Address: _____ Occupation: _____ Home /Cell Phone: _____
City: _____ Weight: _____ Work Phone: _____
Postal Code: _____ Height: _____ Email: _____
Emergency contact: _____ Relationship: _____ Phone number: _____
Doctor: _____ Clinic: _____ Phone number: _____

How would you like appointment reminders (circle one)? Phone Email
How did you hear about our clinic? _____ Do you want our e-newsletters (max. of 3-4/year)? Yes No

How may I help you? (your main concerns): _____

Describe any factors you suspect may have played a role in the onset and worsening of your condition: _____

What have you done to improve the state of your health? _____

Is your health getting better, worse or staying the same? _____

What makes you feel better? _____

What makes you feel worse? _____

Have you consulted a medical doctor about your condition(s)? Explain the diagnosis, therapy and results so far:

Family History (please circle if there is a history of any of the following conditions in your family)

Heart Disease	Alzheimer's	Diabetes	Thyroid Issues	Asthma	Tuberculosis
High Blood Pressure	Mental Illness	Osteoporosis	Celiac Disease	Allergies	Inflammatory Bowel
Stroke	Depression	Psoriasis	Rheumatoid Arthritis	Osteoarthritis	MS
Alcoholism	Drug abuse	Eczema	Learning Disability	Other:	

Does cancer run in your family? If so, what type(s)?

Please list any allergies/sensitivities and the symptoms they cause:
Drugs: _____

Foods: _____

Environmental: _____
Have you consulted a Naturopathic Doctor before? Yes No Who? _____
Have you consulted a Doctor of Chiropractic before? Yes No Who? _____
Have you consulted a Massage Therapist before? Yes No Who? _____
Are you currently working with a professional counsellor, psychologist or psychiatrist? Yes No
Have you been counselled in the past? Yes No If yes what were the circumstances? _____

Please list the 3 most stressful events in your life (past/currently): _____

What is the level of stress currently in your life on a scale of 1-10? _____
List any hospitalizations and surgeries with approximate dates (if you need more space use the back of the page):

List any medical imaging (x-ray, CT, MRI, ultrasound, etc.) with approximate dates and reason for test: _____

List any past accidents or traumas with approximate dates: _____

What is your blood type? (circle) A AB O B Don't know

Childhood history:

Were you born by C section? Yes No Any complications?

Were you breastfed? Yes No If yes, how long (if you know)?

Were you bottle fed? Yes No If yes, starting at what age?

Did you have any food sensitivities/allergies as an infant or child? Yes No
If yes, please list: _____
Did you have any of the following childhood illnesses (circle any that apply)?

Polio	Ear infections	Rheumatic fever	Worms	Frequent colds
Chicken pox	Colic	Whooping cough	Red measles	Bronchitis
German measles	Mumps	Allergies	Eczema/rashes	Pneumonia

Any other significant childhood health issues? _____

Have you ever been diagnosed with (or suspected)?

Parasites	Yes	No	Thyroid disease	Yes	No	Cancer	Yes	No
Mono	Yes	No	Arthritis	Yes	No	Autoimmune Disease	Yes	No
Heart issues	Yes	No	Diabetes	Yes	No	Hepatitis	Yes	No
HIV/AIDS	Yes	No	Circulation issues	Yes	No	Lyme Disease	Yes	No

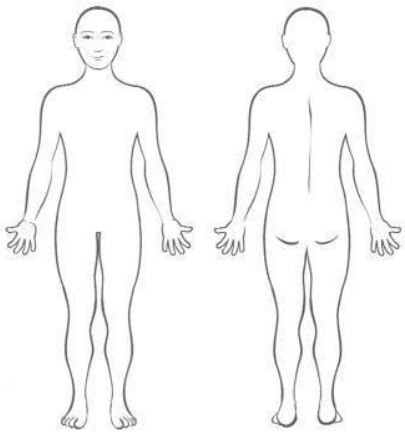
What do you feel is your weakest organ system and why? _____

How many times a year do you have an acute illness (ie. cold/sinusitis/sore throat/bronchitis/flu)? _____
How long do your acute illnesses typically last? _____
Do you exercise regularly? Yes No What type/frequency? _____
Do you drink alcohol Yes No How many drinks/week? _____
Do you use recreational drugs? Yes No What type/frequency? _____
Do you smoke? Yes No If no, were you ever a regular smoker? _____
If yes, Age at starting to smoke and how much do you smoke? _____
Do you wear a medical alert? Yes No Why? _____
Do you have cravings? Yes No What? _____
Are you on a special diet? Yes No Explain diet and reason: _____
How many cups of water do you drink? ___ Circle water type(s): Tap Filtered Reverse osmosis Bottled Spring Well
cups of regular coffee/day? ___ # cups of decaf coffee/day? ___ # cups of diet beverages/day? _____
cups of herbal tea/day? ___ # of cups black/green tea? ___ # of other drinks/day (juice, milk, pop)? ___

How many children do you have? ___ Ages? _____ Do they live with you? _____
Marital status (circle) single married with partner divorced separated widowed

Is your job associated with any potential harmful chemicals or health or life threatening activities?
If so, specify:
What time of day do you have the best energy?
What time of day do you have the least energy?
What is your average energy level on a regular day on a scale of 1-10?

Do you have pain? yes no sometimes
If yes and significant, please mark on diagram below with intensity 0-10 out of 10.
Provide any additional information about the pain beside the diagram (type of pain/past injury/surgery):



Right Side Right Side

Do you have headaches? Yes No If yes, please describe (location, severity, frequency):

Have you ever had a motor vehicle accident (s)? How many? When?
Any serious injuries?
Have you ever had a concussion? How many? When?

Review of symptoms
In all the sections below, please <u>circle any issues that apply</u> currently. If a condition was an issue in the past but not currently, please write P or past.

Skin (circle any that apply): Do you have any of the following rashes, eczema, psoriasis, hives, acne, boils, changes in moles, skin cancer, pre-cancerous lesions, dry skin, itchy skin or night sweats? Other skin issues:

Eyes: Are you near sighted or far sighted? Do you have any eye pain, double vision, glaucoma, low vision, cataracts, blurry vision, dry eyes, itchy eyes, allergic eyes, blepharitis, sties, eye discharge or thinning eyebrows?
Other eye issues:

Head and neck: Do you have headaches, migraines, dizziness, dizziness upon rising, history of head trauma, excessive hair growth, excessive hair loss, dandruff, swollen lymph nodes, thyroid nodules, swelling of the neck or swelling of the throat? Other head and neck issues:
Do you have root canals? Yes No If yes, how many?
Do you have metal fillings? Yes No If yes, how many?

Ears: Do you have ringing in your ears, impaired hearing, earaches, ear discharge, dizziness, wax buildup or itchy ears? Other ear issues:

In all the sections below, please circle any issues that apply currently. If a condition was an issue in the past but not currently, please write P or past.

Cardiovascular system and circulation: Do you have arm/hand or leg/foot swelling, vein issues, extremity numbness, extremity ulcers, deep leg pain, extremity coldness, phlebitis, raynode's syndrome or thinning body hair?
Do you have high blood pressure, high cholesterol, angina, heart murmurs, rheumatic fever, chest pain, heart palpitations, swollen ankles or abnormal heart tests? Other cardiovascular issues: _____

Urinary: Do you have frequent urination, frequent infections, burning on urination, urinary urgency, incontinence, stress incontinence, urination at night, hesitant urination, blood in urine, interstitial cystitis, kidney stones or kidney disease? Other urinary issues _____

Neurological: Have you ever experienced fainting, seizures/convulsions, tingling/numbness, involuntary movements, loss of balance, speech problems, loss of memory, paralysis or stroke? Other neurological issues: _____

Musculoskeletal: Do you have joint pain, joint stiffness, joint swelling, osteoarthritis, rheumatoid arthritis, muscle cramps, backache, neck pain, foot pain, easily sprained joints, heel spurs or gout?
Other musculoskeletal issues: _____

Respiratory: Are you prone to frequent colds, frequent sore throats, tonsillitis, sinusitis, nasal discharge, post nasal discharge, nosebleeds or hoarseness? Do you have seasonal allergies, coughing, wheezing, sputum, coughing up blood, shortness of breath, shortness of breath lying down, pain on breathing, bronchitis, pneumonia or tuberculosis? Other lung or sinus issues: _____

Endocrine: Do you have thyroid issues, heat intolerance, cold intolerance, hypoglycemia, chronic fatigue or diabetes?
Do you get symptoms from delaying a meal? Yes No
Have you experienced any recent weight changes? Yes No If so, have you gained or lost? _____
How many pounds and over what time period? _____

Gastrointestinal: How frequent are your bowel movements? _____ (indicate /day or /week)

Do you have any issues with loose stools, diarrhea, hemorrhoids, fissures, constipation, straining during bowel movements, cramping, abdominal pain, bloating, gas or fecal incontinence?

Do you ever have undigested food in stools, blood in stools, mucous in stools, hard stools, black/tarry stools, yellow/pale stools or greenish stools? Have you ever been diagnosed with an ulcer, IBS, colitis, pancreatitis, Crohn's disease or celiac disease?

Do you have gallbladder disease, gallstones, liver disease, hepatitis, trouble digesting fatty foods, pancreatic issues, reflux, excessive belching, vomiting or heartburn?
Do you have any foods that you suspect make you feel unwell when you eat them? Yes No
If yes, which foods and what is your reaction to them? _____
Other digestive symptoms? _____

Blood: Do you have issues with anemia, low iron, low B12, easy bruising, easy bleeding, past transfusions, lymphatic disease, slow healing wounds or chronically swollen lymph nodes?

Sleep: How many hours of sleep do you get? _____ Is it restful? _____
Do you have any issues with falling asleep, waking through the night, restlessness, waking too early, shift work or trouble waking up in the morning? Any other sleep issues: _____

In all the sections below, please circle any issues that apply currently. If a condition was an issue in the past but not currently, please write P or past.

Emotional: Do you have any issues with anxiety, depression, panic attacks, insomnia, irritability, nervousness, forgetfulness, quick to anger, impatience, seasonal depression or mood swings?

Do you have any phobias? If so, specify: _____

Have you ever had an eating disorder? If yes, explain: _____

Do you enjoy your job (circle any that apply)? Yes No Sometimes

How often do you relax? _____ What do you do to relax? _____

Male Hormones: Do you have prostate enlargement, elevated PSA or a history of prostate surgery?

Have you ever had hernia, testicular pain, testicular masses, genital sores, history of sexually transmitted infections, erectile dysfunction, premature ejaculation, low testosterone or issues with sperm count/motility?

Is your libido average, increased or decreased (circle one)? Are you trying to conceive a baby? Yes No Soon

Last prostate exam: _____ Other male hormonal concerns? _____

Female Hormones:

Are you currently trying to conceive? Yes No If yes, for how long? _____

Are you using birth control? Yes No If yes, what type? _ _____

Are you currently pregnant Yes No If yes, how far along are you? _____ Due date: _____

Number of pregnancies: ____ Number of deliveries: ____ Number of miscarriages: ____ Number of abortions: ____

Do you have periods (circle)? Yes No Irregular If no, when did they stop? _____

Have you had a hysterectomy? Yes No If yes, when and why? _____

Days in your average menstrual cycle (day 1 of flow to day 1 of next flow)? _____

Do you have any issues with irregular cycles, spotting between periods, heavy flow, scanty flow, clots in flow, fibroids, endometriosis, painful ovulation, painful periods, PMS or trouble conceiving?

Have you ever had ovarian cysts, been diagnosed with PCOS (polycystic ovarian syndrome), excessive facial hair, thinning hair or issues with acne?

Do you have any issues with vaginal discharge, vaginal itching, vaginal dryness, pain on intercourse, hot flushes, night sweats, breast lumps, breast tenderness, breast implants or nipple discharge?

Do you take any hormones? Yes No If so, what type and duration? _____

Last Pap: _____ Last breast exam: _____

Other gynecological issues? _____

Is there anything else important to you that has not been addressed? _____

MEDICATION & SUPPLEMENT HISTORY

NAME: _____ DATE: _____

Please record from the most recent to the most **distant** (past). The most important inclusions are the things you are currently taking and the things you have taken for a substantial length of time in the past. Please indicate *all natural remedies and pharmaceutical medications* (prescription and non-prescription) you are currently taking and when you started them. Please continue on the back if necessary. Bring any containers of medication, supplements or vitamins you are taking now.

If you recall additional medications that you took in the past please add them along with the approximate dates or length of time they were taken. Please indicate if the medication/supplement was effective for you and/or any negative reactions or significant side effects.

Drug or Natural Medication	Present/Past	Start Date	Stop Date	Reason for it and result

AXILLARY TEMPERATURE TEST

Name: _____ Date: _____

There is considerable evidence that the current tests for the diagnosis of hypothyroidism (low thyroid function) are insensitive and somewhat lacking in accuracy.

Dr. Broda Barnes, M.D., Endocrinologist and thyroid specialist, explains in his book "Hypothyroidism, an Unsuspected Illness" his feelings and theories about this matter. He proposes that the most sensitive and accurate test for picking up the most people with low thyroid function is simply to check the most basic function of the thyroid. The thyroid regulates the metabolic furnace of the body, i.e. create heat or control temperature. Dr. Barnes feels that the recording of basal body temperature daily for six days is the most simple and best means of doing this. For accuracy, he insists that the patient is at rest, first thing in the morning and relaxed.

Instructions:

1. Use an thermometer, which has been shaken down the night before (if mercury) or a digital thermometer that's meant for axillary or basal use. Put it on your bedside table before falling asleep.

2. When you wake up put the thermometer in your armpit (10 minutes for mercury or until it beeps if digital). Record a temperature each morning for six days. Do this before you have gotten out of bed, urinated, had coffee, had food, done any activity, mental or physical. An axillary (armpit) temperature is suggested, rather than the mouth, because so many people have low grade unsuspected sinus infections which generate heat only in that area, thereby falsely raising the oral temperature.

3. For women, additional consideration is needed during ovulation, which elevates temperature somewhat. Because of this, women who menstruate should start the recording on the second or third day of their cycle. For men, or women who are menopausal, it makes no difference which day is picked.

We are attempting to search out and find the undiscovered hypothyroidism that our patients have, since this is such a common and easily treatable ailment. Barnes estimates that approximately 40% of the adult population has this problem and it can be associated with hypoglycemia and allergies, psoriasis, acne, undiagnosed skin problems, hypertension, obesity, depression and many other ailments. If you have any unusual reaction while this is going on, or anything you wish to share, please indicate this on the recording sheet.

DATE:	TEMPERATURE VALUE
1.	
2.	
3.	
4.	
5.	
6.	

Bring this into the office for the doctor to look over. Below 97.8 ° F or 36.5 ° C is considered low. If the majority of the temperature data is low, it may suggest low thyroid function.

DYSBIOSIS QUESTIONNAIRE AND SCORE SHEET

This questionnaire is designed for adults and the scoring system isn't as appropriate for children. It lists factors in your medical history which are known to contribute to the disruption of normal healthy gastrointestinal bacteria, directly or indirectly promoting the overgrowth of yeasts, fungi and other pathogens, (Section A) and symptoms commonly found in individuals with dysbiosis related illness (Section B and C).

For each "yes" answer in Section A, circle the Point Score in that section. Total your score and record it in the box at the end of the section. Then move on to Section B and C and score as directed.
Filling out and scoring this questionnaire should help you and your physician evaluate the possible role of dysbiosis in contributing to your health problems. Yet it will not provide an automatic "yes" or "no" answer.

Note: Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines has been disrupted, leaving it open to the overgrowth of yeast, fungi, parasites and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely affects other important organ systems via toxic stress and interfering with nutrient absorption and utilization.

Section A: History	**Point Score**		**Point Score**
1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for skin acne or anything else for one month or longer?	**25**	**9.** Does exposure to perfumes, insecticides, fabric shop odours and other chemicals provoke..... Moderate to severe symptoms? Mild symptoms? List symptoms	 **20** **5**
2. Have you, at any time in your life, taken other "broad spectrum" antibiotics for respiratory urinary or other infections for 4 or more courses in a 1 year period?	**20**	**10.** Are your symptoms worse on damp, muggy days or in moldy places? List symptoms	**20**
3. Have you ever taken a broad spectrum antibiotic drug – even a single dose?	**6**	**11.** Have you had athlete's foot, ring worm, jock itch or other chronic fungal infections of the skin or nails? Have such infections been..... Severe or persistent? Mild to moderate?	**Y/N** **20** **10**
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**	**12.** Do you crave sugar? **13.** Do you crave breads? **14.** Do you crave alcoholic beverages? **15.** Does tobacco smoke really bother you?	**10** **10** **10** **10**
5. Have you taken birth control pills? For more than 5 years? For more than 2 years? For 6 months to 2 years?	 **25** **15** **8**	**16.** Have you consumed chlorinated (or chemically treated) drinking water for 3 or more months?	**15**
6. Have you been pregnant? 2 or more times? 1 time?	 **5** **3**	**17.** Do you consume commercially raised meats (antibiotic fed) on a regular basis?	**15**
7. Have you taken Prednisone, Decadron or other cortisone type drugs? For more than 6 months? For more than 2 weeks? For 2 weeks or less?	 **25** **15** **6**	**18.** Do you eat processed foods regularly? **19.** Do you drink alcohol or consume coffee daily? **20.** Do you have or have you ever had an ulcer, colitis, crohn's disease or diverticulitis?	**20** **20** **35**
8. Have you ever had parasitic infections, dysentery or unexplained episodes of prolonged diarrhea and/or intestinal distress?	**15**	**TOTAL SCORE, SECTION A**	

Section B: Major Symptoms For each of your symptoms, enter the Appropriate figure in the Point Score Column: If a symptom is occasional or mild score 3 pts. If a symptom is frequent &/or moderate score 6 pts. If a symptom is severe or disabling score 9 pts. Add total score and record it in the box at the end of this section.	**Point Score**	**Section C: Other Symptoms** For each of your symptoms, enter the appropriate figure in the Point Score Column: If a symptom is occasional or mild score 1 pt. If a symptom is frequent &/or moderately severe score 2 pts. If a symptom is severe or disabling score 3pts. Add total score and record it in the box at the end of this section.	**Point Score**
1. Fatigue or lethargy		**1.** Drowsiness	
2. Feeling of being "drained**"**		**2.** Irritability	
3. Poor memory		**3.** Lack of co-ordination	
4. Feeling "spacey" or "unreal"		**4.** Inability to concentrate	
5. Depression		**5.** Frequent mood swings	
6. Numbness, burning or tingling		**6.** Headache	
7. Muscle aches		**7.** Dizziness or loss of balance	
8. Muscle weakness or paralysis		**8.** Pressure above ears/feeling of head swelling and tingling	
9. Pain and/or swelling in joints		**9.** Itching	
10. Abdominal pain		**10.** Rashes	
11. Constipation		**11.** Heartburn	
12. Diarrhea		**12.** Indigestion	
13. Bloating		**13.** Belching and intestinal gas	
14. Troublesome vaginal discharge		**14.** Mucus in stool	
15. Persistent vaginal burning or itching		**15.** Hemorrhoids	
16. Prostatitis		**16.** Dry mouth	
17. Impotence		**17.** Rash or blisters in mouth	
18. Loss of sexual drive		**18.** Bad breath	
19. Endometriosis		**19.** Nasal congestion	
20. Cramps and/or other menstrual irregularities		**20.** Joint swelling or arthritis	
21. Premenstrual tension		**21.** Postnasal drip	
22. Spots in front of eyes		**22.** Nasal itching	
23. Erratic vision		**23.** Sore or dry throat	
24. Eczema, dermatitis, psoriasis		**24.** Cough	
		25. Pain or tightness in chest	
TOTAL SCORE, SECTION B		**26.** Wheezing or shortness of breath	
		27. Urgency or urinary frequency	
TOTAL SCORE, SECTION C		**28**. Burning on urination	
		29. Failing vision	
TOTAL SCORE, SECTION A		**30.** Burning or tearing of eyes	
		31. Recurrent infection or fluid in ears	
		32. Ear pain or hearing loss	
GRAND TOTAL SCORE, SECTIONS A, B & C		**TOTAL SCORE, SECTION C**	

The Grand Total Score will help you and your physician decide if your health problems are dysbiosis related. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

Dysbiosis related health problems are **almost certainly** present in women with scores over 180, and in men with scores over 140.

Dysbiosis related problems are **probably** present in women with scores over 120**,** and men with scores over 80.

With scores of less than 60 in women and 40 in men, dysbiosis is unlikely to be contributing to your health challenges.

the naturopathic care centre

CONSENT TO USE AND DISCLOSE PERSONAL INFORMATION

Privacy of your personal information is an important part of my clinic. My staff and I are committed to collecting, using and disclosing your personal information responsibly. All staff members are aware of the sensitive nature of the information that you have disclosed to us and are trained in the appropriate use and protection of your information. We promise that only necessary information is collected about you and we only share your information with your consent. The Naturopathic Care Centre will be the health information custodian of your patient file. Our storage retention and destruction of your personal information complies with existing legislation with the College of Naturopaths of Ontario.

This clinic will collect, use and disclose your information for the following purposes:

- ❑ To assess your health concerns and provide health care
- ❑ To establish and maintain contact with you, or send newsletters
- ❑ To communicate with other health-care providers only with your consent
- ❑ To allow us to efficiently follow-up for treatment, care and billing
- ❑ To invoice for goods and services and to process credit card payments

DECLARATION AND RELEASE: CONSENT TO TREATMENT

This is to acknowledge and declare that I have been informed of and understand that:

- ❑ Any treatment or advice provided to me as a client of Dr. Carrie Meszaros, N.D., R.Ac. 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 practitioner.
- ❑ I have the option to seek or continue conventional medical care from a conventional medical doctor. Dr. Carrie Meszaros, N.D., R.Ac. does not suggest to refrain from seeking or following conventional medical treatment if I choose to do so.
- ❑ Doctors of Naturopathic Medicine are trained to read and interpret x-ray reports, ultra sound reports and other conventional imaging tests but are restricted from ordering them in the Province of Ontario. Naturopathic Doctors have access to some blood tests in the Province of Ontario but not all. Therefore, it is my responsibility to maintain contact with a Medical Doctor so that all necessary testing may be performed as required to monitor my condition.
- ❑ Doctors of Naturopathic Medicine may use testing procedures that are not conventional to make an assessment of the progress of their therapies.
- ❑ Dr. Carrie Meszaros, N.D., R.Ac. does not treat cancer, auto-immune disease, genetic disease, HIV/AIDS etc., rather she will help me assess and correct imbalances in my body, nutrition and lifestyle so that my body can then achieve a state of better health.
- ❑ I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with Naturopathic medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, or interactions with prescription medications.
- ❑ Acupuncture is very safe but rarely can cause slight pain, light-headedness, headaches, nausea, soreness, bruising, bleeding or infection, and the very rare possibility of more serious medical consequences of needle punctures such as pneumothorax or nerve damage. I will notify Dr. Carrie Meszaros ND, R.Ac., prior to acupuncture if I have or suspect I have any blood borne infectious (hepatitis, HIV) or serious bleeding disorders.
- ❑ As with all forms of therapy, I understand that naturopathic treatment also has its limitations and thus I understand that the results are not guaranteed. Dr. Carrie Meszaros N.D., R.Ac. will make every attempt to explain likely risks and side effects of treatment, I acknowledge that not all risks and complications can be predicted prior to beginning new treatments.
- ❑ In the event of a medical emergency, I am advised to seek conventional medical care at a hospital.
- ❑ I, _____ (print name) agree to pay my account in full at every visit and whenever remedies are purchased. I have read and understand the fee schedule that was given to me. I have read the attached information about naturopathic medicine. I understand that treatment recommendations may include but are not limited to homeopathy, acupuncture, botanical medicines, vitamin and mineral therapy, nutrition, lifestyle counseling, stress management and physical therapies. I always have the right to discuss and ask questions about any therapy that is proposed and I am able to withdraw my consent for specific therapies or treatments if I am not comfortable. With this knowledge, I voluntarily consent to The Naturopathic Care and I intend for this consent form to cover my entire course of treatment.

By signing this form I authorize and consent Dr. Carrie Meszaros, N.D., R.Ac. to provide treatment to me and to collect, use and/or disclose my personal information as outlined in this document.

Dated and signed this _____day of _____, 20_____

Patient's Signature (or signature of parent or legal guardian) _____

Naturopathic Doctor's Signature _____

288 Wellington Street, Stratford, ON N5A 2L9 Telephone 519-271-2440 reception@carriemeszarosnd.ca

Diet Diary

Meal	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							
Water Cups/day							
Other Beverages							
Exercise Type & Duration							

Diet/Activity report: Please take the time to complete the following survey carefully and accurately. List in detail the quantity and exact nature of all foods and beverages consumed. (i.e. frozen, canned etc.). Please also include any condiments and/or fats in each meal or snack.