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

the naturopathic care centre

2023 Fee Schedule and Office Policies
Dr. Carrie Meszaros, B.Sc., N.D., R.Ac.

Naturopathic Visits (in person or phone/video visits)

Initial Consultation, adults and children (up to 60 minutes)	$200
Second Visit (up to 45 minutes)	$145
Extended Second Visit (up to 60 minutes)	$185
Naturopathic Consultation (up to 30 minutes)	$105
Naturopathic Consultation (up to 45 minutes)	$145
Naturopathic Consultation (up to 60 minutes)	$185
Naturopathic Consultation (up to 15 minutes)	$ 60
Naturopathic Consultation (5 minutes)	$ 20
Naturopathic Re-Assessment (18 months since last appointment) 45-60 min	$185
Naturopathic Acupuncture Treatment (without consultation) up to 30 min	$ 85
Naturopathic Acupuncture with Consultation (up to 30 minutes)	$105
Naturopathic Acupuncture with Consultation (up to 45 minutes)	$145
Naturopathic Acupuncture Treatment with Consultation (up to 60 minutes)	$185

Registered Acupuncture Visits (**Patients that are currently naturopathic patients are exempt from the initial and second visit acupuncture assessments, instead they will usually be billed for a 45 minute acupuncture consultation to start a registered acupuncture file)*

*Initial Acupuncture Consultation (non-naturopathic patient) (60 minutes)	$200
*Second Acupuncture Visit (for non-naturopathic patient) (45 minutes)	$145
Acupuncture Treatment (without consultation) up to 30 min	$ 85
Acupuncture with Consultation (up to 30 minutes)	$105
Acupuncture with Consultation (up to 45 minutes)	$145

Services and Fees

Cancelled Appointment - with less than 48 hours notice	50% of originally scheduled visit
Missed Appointment - without notice	100 % of originally scheduled visit
Simple doctor's notes and prescription refills without office visit	$ 25
Email consults and comprehensive medical forms and reports	fee based on complexity/time

Within one business day of booking a new patient visit, $100 deposit is required to finalize the booking (instructions on how to pay in your booking confirmation). This $100 will be used toward payment for your first visit. **If this deposit is not received within 48 hours of booking your appointment, your appointment will be cancelled.** If a new patient visit is rescheduled more than 48 hours before a new patient booking this deposit can be transferred to a rescheduled appointment. Cancellations or rescheduling with less than 48 hours notice before an appointment will forfeit this deposit as per our cancellation policy.

We request a minimum of 48 hours notice for all types of visits if you cannot keep your appointment. Our answering machine and email are available during times when our office is closed. If you would like to reschedule 3 days or more before your appointment this can be done through our online booking. Adequate notice allows us to fill the time set aside for your appointment with a patient on our wait list.
Cancellations with less than 48 hours notice will be charged 50 % of scheduled visit cost. If your appointment is missed without a cancellation call or email you will be charged 100% amount of the visit. We do understand extenuating circumstances might apply which may make 48 hours notice impossible and take these under consideration when enforcing our late cancellation policy (emergencies/illness/weather/unforeseen events). There is never a charge to change an in person visit into a virtual visit which can be conducted by phone or through video. 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 at times in patient care and in these circumstances; we appreciate your patience and understanding.

All consultation services are not currently subsidized by OHIP. All naturopathic & acupuncture visits are exempt from HST.
Fees for health services and supplements are due when services are rendered and may be paid by cash, Visa, MasterCard or Debit. **We ask all telemedicine patients to have a valid credit card number on file with our office.**

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 may be subject to a fee depending on length of time required. Telephone calls and emails that require more than 5 minutes from our Naturopathic Doctor/Acupuncturist will be billed as consultations.

I have read and fully understood this fee schedule and office policies and I accept the terms outlined. In the case of a no show or last minute cancellation I accept the fees associated and authorize the charges.

Patient's or guardian's signature _____ Dated _____

Naturopathic Patient Intake Form

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

Date:

Name: Occupation:

Age: Date of Birth:

Address including city and postal code:

Phone numbers: Cell Home Alternate

Email:

Do you give permission for us to send appointment reminders by email/text? ☐ Yes ☐ No

Emergency contact: Relationship: Phone number:

Doctor: Clinic: Phone number:

How did you hear about our clinic?

Do you want our e-newsletters about holiday closures and clinic news (<3x/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:

Allergies: please list and make a note of what type of reaction

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

☐ heart disease	☐ depression	☐ rheumatoid arthritis
☐ stroke	☐ mental illness	☐ osteoarthritis
☐ Alzheimer's or dementia	☐ osteoporosis	☐ MS
☐ diabetes	☐ celiac disease	☐ alcoholism
☐ thyroid Issues	☐ allergies	☐ drug abuse
☐ asthma	☐ inflammatory bowel disease	☐ eczema
☐ high blood pressure	☐ psoriasis	☐ learning disability

Does cancer run in your family?

If so, what type(s)?

Other significant conditions in family history:

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 or time periods in your life (past or currently):

What is the level of stress currently in your life on a scale of 1-10?

Number of motor vehicle accident (s)? ☐ When? ☐ Any serious injuries?

Have you ever had a concussion? ☐ Yes ☐ No How many? ☐ When? ☐

List any hospitalizations and surgeries with approximate dates

List any past accidents or traumas with approximate dates:

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

What is your blood type? ☐ A ☐ AB ☐ O ☐ B ☐ Don't know

Height: Weight**:**

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

☐ frequent ear infections	☐ rheumatic fever	☐ allergies
☐ eczema	☐ bronchitis	☐ red measles
☐ colic	☐ whooping cough	☐ polio
☐ mumps	☐ pneumonia	☐ chicken pox

Any other significant childhood health issues?

Have you ever been diagnosed with (or suspected)?

☐ parasites	☐ arthritis	☐ cancer
☐ mono	☐ diabetes	☐ autoimmune disease
☐ HIV/AIDS	☐ pre-diabetes	☐ hepatitis
☐ thyroid disease	☐ circulation issues	☐ Lyme Disease

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? ☐ What type of water do you drink?

☐ 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)? ☐ Please specify type:

How many children do you have? ☐ Ages? Do they live with you?

Marital status: ☐ 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?

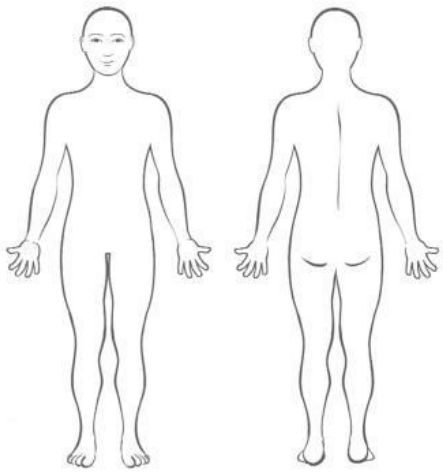
What is your average energy level on a regular day on a scale of 1-10?

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

Do you have pain? ☐ yes ☐ no ☐ sometimes

If yes and significant, please mark on diagram or describe 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

Review of symptoms

In all the sections below, please indicate issues that affect you currently. If a condition was a significant issue in the past but not currently, please make a note about it in the other text field.

Skin: 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
- ☐ night sweats

Other skin conditions:

Eyes:

- ☐ near sightedness
- ☐ far sightedness
- ☐ eye pain
- ☐ double vision
- ☐ glaucoma
- ☐ low vision
- ☐ cataracts
- ☐ macular degeneration
- ☐ blurry vision
- ☐ diabetic retinopathy
- ☐ dry eyes
- ☐ itchy eyes
- ☐ allergic eyes
- ☐ blepharitis
- ☐ sties
- ☐ eye discharge
- ☐ thinning eyebrows

Other eye issues:

Head and neck:

- ☐ headaches
- ☐ migraines
- ☐ swollen lymph nodes
- ☐ dizziness upon rising
- ☐ history of head trauma
- ☐ excessive hair growth
- ☐ excessive hair loss
- ☐ dandruff
- ☐ thyroid nodules
- ☐ swelling of the neck
- ☐ swelling of the throat
- ☐ vertigo
- ☐ ringing in the ears
- ☐ impaired hearing
- ☐ earaches
- ☐ stuffy ears
- ☐ wax buildup
- ☐ itchy ears

Do you have root canals? ☐ Yes ☐ No If yes, how many?

Do you have metal fillings? ☐ Yes ☐ No If yes, how many?

Any dental issues currently or significant in the past?

Cardiovascular system and circulation: **Do you have any of the following**?

- ☐ high blood pressure
- ☐ high cholesterol
- ☐ angina
- ☐ heart murmurs
- ☐ congestive heart failure
- ☐ chest pain
- ☐ heart palpitations
- ☐ swollen ankles/feet/hands
- ☐ atrial fibrillation
- ☐ vein issues
- ☐ deep leg pain
- ☐ history of clots or phlebitis
- ☐ varicose veins
- ☐ raynode's syndrome
- ☐ thinning body hair
- ☐ history of rheumatic fever
- ☐ history of heart attack
- ☐ history of stroke

Other cardiovascular conditions:

Urinary System:

- ☐ frequent urination
- ☐ frequent infections
- ☐ burning on urination
- ☐ urinary urgency
- ☐ incontinence
- ☐ stress incontinence
- ☐ urination at night
- ☐ hesitant urination
- ☐ blood in urine
- ☐ interstitial cystitis
- ☐ kidney stones
- ☐ kidney disease

Other urinary issues:

Neurological:

- ☐ history of fainting
- ☐ seizures/convulsions
- ☐ tingling/numbness
- ☐ involuntary movements
- ☐ loss of balance
- ☐ speech problems
- ☐ loss of memory
- ☐ paralysis
- ☐ tremors

Other neurological issues:

Musculoskeletal:

- ☐ joint pain
- ☐ joint stiffness
- ☐ joint swelling
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ muscle cramps
- ☐ backache
- ☐ neck pain
- ☐ foot pain
- ☐ easily sprained joints
- ☐ gout
- ☐ joint replacements

Other musculoskeletal issues:

Respiratory:

- ☐ frequent colds
- ☐ frequent sore throats
- ☐ tonsillitis
- ☐ sinusitis
- ☐ nasal discharge
- ☐ post nasal discharge
- ☐ nosebleeds
- ☐ deviated septum
- ☐ hoarseness
- ☐ seasonal allergies
- ☐ coughing
- ☐ wheezing

- [ ] sputum
- [ ] shortness of breath lying down
- [ ] history of pneumonia
- [ ] coughing up blood
- [ ] pain on breathing
- [ ] history of tuberculosis
- [ ] shortness of breath
- [ ] frequent bronchitis

Other lung or sinus issues: _____

Endocrine

- [ ] hypothyroidism
- [ ] heat intolerance
- [ ] diabetes
- [ ] hyperthyroidism
- [ ] cold intolerance
- [ ] chronic fatigue
- [ ] hashimoto's
- [ ] hypoglycemia
- [ ] high prolactin
- [ ] thyroid nodules
- [ ] pre diabetes

Other endocrine issues:

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

Digestive: How frequent are your bowel movements (indicate number per day or per week)?

- [ ] loose stools
- [ ] ulcerative colitis
- [ ] gallbladder disease
- [ ] diarrhea
- [ ] Crohn's disease
- [ ] gallstones
- [ ] hemorrhoids
- [ ] Celiac disease
- [ ] gallbladder removed
- [ ] fissures
- [ ] heartburn
- [ ] liver disease
- [ ] constipation
- [ ] reflux
- [ ] hepatitis
- [ ] straining
- [ ] history of pancreatitis
- [ ] trouble digesting fatty foods
- [ ] cramping
- [ ] blood in stools
- [ ] pancreatitis
- [ ] abdominal pain
- [ ] mucous in stools
- [ ] excessive belching
- [ ] bloating or gas
- [ ] hard stools
- [ ] vomiting
- [ ] IBS
- [ ] black/tarry stools
- [ ] nausea
- [ ] undigested food in stools
- [ ] yellow/pale/green stools
- [ ] loss of bowel control (accidents)

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 any of the following?

- ☐ history of anemia
- ☐ low iron
- ☐ low B12
- ☐ easy bruising
- ☐ easy bleeding
- ☐ past transfusions
- ☐ lymphatic disease
- ☐ slow healing wounds
- ☐ clotting issues

Sleep:

How many hours of sleep do you get? Is it restful?

- ☐ issues falling asleep
- ☐ waking in the night
- ☐ restless legs
- ☐ waking too early shift work
- ☐ trouble waking in the morning
- ☐ shift work
- ☐ sleep apnea
- ☐ snoring

Has anyone ever reported that you snore or pause breathing in your sleep?

Any other sleep issues:

Emotional:

- ☐ anxiety
- ☐ depression
- ☐ bipolar diagnosis
- ☐ panic attacks
- ☐ insomnia
- ☐ irritability
- ☐ nervousness
- ☐ forgetfulness
- ☐ quick to anger
- ☐ impatience
- ☐ seasonal depression

Other mood issues:

- ☐ anorexia
- ☐ bulimia
- ☐ binge eating
- ☐ other disordered eating
- ☐ mood swings

Do you have any phobias? ☐ Yes ☐ No If so, specify

Have you ever had an eating disorder? ☐ Yes ☐ No 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?

Hormones (answer questions that are applicable, leave blank any that aren't applicable):

- ☐ prostate enlargement
- ☐ elevated PSA
- ☐ prostate surgery?
- ☐ hernia
- ☐ testicular pain
- ☐ testicular masses
- ☐ erectile dysfunction
- ☐ premature ejaculation
- ☐ low testosterone
- ☐ issues with sperm count/motility

last prostate exam

Any history of sexually transmitted infections? ☐ Yes ☐ No Specify:

Hormones continued

☐ genital sores or rashes ☐ decreased libido ☐ increased libido

Are you currently trying to conceive? ☐ Yes ☐ No ☐ Soon

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 live births: ☐ Number of stillbirths: ☐

Number of miscarriages: ☐ If miscarriages, how far along were you?:

If you have a history of abortion, how many?

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
☐ trouble conceiving?
☐ history of ovarian cysts
☐ PCOS (polycystic ovarian syndrome)
☐ excessive facial hair
☐ thinning hair
☐ issues with acne
☐ vaginal discharge
☐ vaginal itching
☐ vaginal dryness
☐ pain on intercourse
☐ hot flushes
☐ night sweats
☐ breast lumps
☐ breast tenderness
☐ breast implants
☐ nipple discharge?

Last Pap: Last breast exam: Other hormonal/gynecological issues?

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

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

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. I also consent to reminder emails and texts from the online scheduler. If I choose not to use the online schedule system for reminders, I am aware that I am responsible to keep track of my own appointments as reminders will not be given.

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.