



**Please Read First**

*Dear New Client,*

*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 enclosed 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 in advance of 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 the answer to, simply leave it blank and we can talk about it in the consultation.*

***Please fill out forms to the best of your ability and bring completed forms with you to initial consultation. If you have any recent medical test results that are relevant, please bring them along to your appointment. Also, please bring any 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, contra-indication, possible adverse reactions and toxicities of natural remedies.*

*Naturopathic doctors work with their patients to prevent and treat acute and chronic illness. We restore health and establish optimal fitness by supporting the body's ability to heal itself through natural treatments and by treating the underlying cause of the illness rather than simply eliminating or suppressing symptoms.*

*Treatments used in my naturopathic practice include: clinical nutrition and supplementation, homeopathy, botanical medicine, acupuncture, hydrotherapy 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 with me during our consultation.*

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

***Carrie Meszaros, B.Sc. (Hons.), N.D.***



### Fee Schedule and Office Policies

\*\* These services are **not currently subsidized by OHIP**

\*\* Prices listed do not include the HST

Initial Consultation – adult - (1 hour)	\$140.00
Initial Child Consultation – child – (45 – 60 min)	125.00
Second Visit (45 minutes)	105.00
Naturopathic Consultation (1/2 hour)	70.00
Naturopathic Consultation (45 minutes)	95.00
Naturopathic Review (10-15 minutes)	40.00
Naturopathic Re-Assessment (18 months since last appointment)	105.00
Initial Acupuncture and Consultation	70.00
Acupuncture + Short Consultation	70.00
Acupuncture without Consultation	55.00
Doctor's Notes	15.00
Cancelled Appointment (with less than 24 hours notice)	30.00
Missed Appointment (with no notice)	40.00

#### **Lab Services**

ZincTally Test	5.00
Koenisburg Test	7.50
Urinary Indican	14.00
HCG	12.00
Blood Type Test	7.00
Oxidata	16.50
Dip	7.00

Fees for health services and supplements are **due when services are rendered** and may be paid by cash, cheque, Visa, Mastercard or Debit. There will be a \$20.00 fee for NSF cheques.

We respectfully request a **minimum of 24 hours notice** in the event you cannot keep your appointment. **Without minimum notice we will charge \$30.00 for the appointment.** Our answering machine is available during off hours to take any messages.

**If an appointment is missed without a cancellation call, you will be charged \$40.00.**

For the respect and convenience of our clients 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. **Please note that when you arrive late for your appointment, only the balance of time that was booked for you can be used.**

Telephone consultations provide a professional service and as such may be subjected to a fee on the discretion of the Naturopathic Doctor.

Carrie Meszaros, B.Sc. (Hons.), N.D.

I have read and fully understood the above description of this fee schedule and office policies and I agree to honour it  
\_\_\_\_\_ clients or guardians signature

**Children's Intake Form**

**Carrie Meszaros, B.Sc. (Hons.), N.D.**

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Who does the child live with (circle)? Both Parents    Mother    Father    Other: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

How did you hear about this office? \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Would you like our E-newsletter? \_\_\_\_\_

In case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

How may I help you? (your child's main concern): \_\_\_\_\_

Describe carefully any factors that you may suspect have played a role in the onset and perpetuation: \_\_\_\_\_

Have you attempted to treat this in the past? If so, what treatments have you tried? What were the results?

What seems to make it better? \_\_\_\_\_

What seem to make it worse? \_\_\_\_\_

Secondary concern(s)? \_\_\_\_\_

Have you consulted a medical doctor regarding your child's condition? Please explain his/her diagnosis, therapy and results: \_\_\_\_\_

Have you consulted a Naturopathic Doctor before?    Y    N    Who? \_\_\_\_\_

Have you consulted a Chiropractic Doctor before?    Y    N    Who? \_\_\_\_\_

Has your child been counseled in the past?    Y    N    What were the circumstances? \_\_\_\_\_

Please list the three most stressful events in your child's life (past or present) \_\_\_\_\_

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

Drugs: \_\_\_\_\_

Foods: \_\_\_\_\_

Environment: \_\_\_\_\_

Family History: Please circle if there is any family history of the following conditions in your family

Heart Disease	MS	Diabetes	Thyroid Problems	Asthma
Tuberculosis	Alcoholism	Drug abuse	Rheumatoid arthritis	Allergies
Psoriasis	Eczema	Mental illness	Osteoarthritis	Kidney disease
Alzheimers	Celiac disease	Depression	High blood pressure	Learning disability

Does cancer run in your family? If so, what type? \_\_\_\_\_

Other: \_\_\_\_\_

**Personal Medical History**

List any hospitalizations & surgeries (date/why?)

Please circle child's blood type: A B O AB  
List X rays, CT scans, EKG's, MRI's (date/why?)

List any past traumas or accidents with the date:

Please circle the immunizations that your child has received:

Hepatitis B	DPT (diphtheria, pertussis, tetanus)	Hemophilus B
Polio	MMR (measles, mumps, rubello)	Hepatitis A
Flu	DT (diphtheria, and tetanus)	Smallpox

Other: \_\_\_\_\_

Did your child have a reaction after any immunizations? If so, which immunizations and describe the reactions: \_\_\_\_\_

**Prenatal History**

Were there any difficulties during pregnancy? Yes No

Please check any experienced:

- |   |   |
|---|---|
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> High blood pressure    |
| <input type="checkbox"/> Thyroid conditions   | <input type="checkbox"/> Toxemia                |
| <input type="checkbox"/> Nausea and vomiting  | <input type="checkbox"/> Bleeding               |
| <input type="checkbox"/> Emotional trauma     | <input type="checkbox"/> Threatened miscarriage |
| <input type="checkbox"/> Physical trauma      | <input type="checkbox"/> Other: _____           |

Were there any interventions during the birth (i.e. Medications, epidural, forceps, vacuum, induction, C section)? \_\_\_\_\_

Were there any health problems after birth? \_\_\_\_\_

Was your child breast fed? How long? \_\_\_\_\_

Was formula used? What type and for how long? \_\_\_\_\_

What foods were introduced first? When? \_\_\_\_\_

When was cow's milk introduced? \_\_\_\_\_

Is there anything that you exclude from your child's diet (i.e. vegetarian)? \_\_\_\_\_

How does your child eat? (good, picky eater, often, eats little, eats a lot) \_\_\_\_\_

How much does your child drink? What does he/she drink? \_\_\_\_\_

When did your child achieve developmental milestones(circle) Early Average Late

How many hours of sleep does your child get per night? \_\_\_\_\_ Is it restful? \_\_\_\_\_

Please check any of the following your child has had in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Diaper rash                        | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Strep throat       |
| <input type="checkbox"/> Eczema                             | <input type="checkbox"/> Whooping cough           | <input type="checkbox"/> Frequent colds     |
| <input type="checkbox"/> Frequent diarrhea                  | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Ear infections     |
| <input type="checkbox"/> Constipation                       | <input type="checkbox"/> Psoriasis                | <input type="checkbox"/> Chicken pox        |
| <input type="checkbox"/> Cradle cap                         | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Measles            |
| <input type="checkbox"/> Cavities                           | <input type="checkbox"/> Tummy aches              | <input type="checkbox"/> Mumps              |
| <input type="checkbox"/> Excess perspiration                | <input type="checkbox"/> Bedwetting               | <input type="checkbox"/> Rubella            |
| <input type="checkbox"/> Growing pains                      | <input type="checkbox"/> Chronic nasal congestion | <input type="checkbox"/> Joint problems     |
| <input type="checkbox"/> Bloody noses                       | <input type="checkbox"/> Fecal incontinence       | <input type="checkbox"/> Insomnia           |
| <input type="checkbox"/> Motion sickness                    | <input type="checkbox"/> Gas                      | <input type="checkbox"/> Worms/parasites    |
| <input type="checkbox"/> Colic                              | <input type="checkbox"/> Swollen glands           | <input type="checkbox"/> Allergies          |
| <input type="checkbox"/> Weight loss/ failure to grow       | <input type="checkbox"/> Fears (specify) _____    | <input type="checkbox"/> Bladder infections |
| <input type="checkbox"/> Problems at school (specify) _____ |   |   |
| <input type="checkbox"/> Other: _____                       |   |   |

Is there anything else that you feel is important but has not been asked? \_\_\_\_\_

## 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 time. Please include any reactions you have experienced. Also please indicate those you are on presently, when you started them and approximately how long you were on various medications in the past. Please continue on the back if necessary. Please include all prescription and non-prescription medicines, herbal supplements and vitamins. Bring any containers of medication, supplements or vitamins you are taking now.

DRUG OR NATURAL MEDICATION	PRESENT/PAST	START DATE	STOP DATE	REASON FOR IT AND RESULT

### Diet Diary

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

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. (ie: frozen, canned etc.). Please also include any condiments and/or fats in each meal or snack.



**CARRIE MESZAROS B.Sc., N.D.**  
288 Wellington St., Stratford, ON N5A 2L9

**DECLARATION AND CONSENT TO TREATMENT OF A CHILD**

- I This is to acknowledge that I have been informed and I understand that:
  - i. Any treatment or advice provided by Carrie Meszaros, N.D. for my child is not exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care practitioner
  - ii. I am at liberty to seek or continue medical care for my child from physicians or other health care providers who are qualified to practice in Ontario
  - iii. Carrie Meszaros, N.D. has not suggested to me to refrain from seeking or following the advice of another licensed health care provider for my child
- II I declare that I have received a full and complete explanation of the treatment and/or services that my child will receive from Carrie Meszaros, N.D. and hereby authorize and consent to my child's treatment by her
- III I agree to pay the full account at the time of each visit or treatment

**CONSENT FOR THE USE AND DISCLOSURE OF PERSONAL INFORMATION**

Privacy of your personal information is an important part of our clinic. We 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. Our storage, retention and destruction of your personal information complies with existing legislation with the Board of Directors of Drugless Therapy-Naturopathy and privacy protection protocol.

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

- i. To assess your health concerns and provide health care
- ii. To establish and maintain contact with you
- iii. To send newsletters and other information mailings
- iv. To remind you of upcoming appointments
- v. To communicate with other treatment health-care providers
- vi. To allow us to efficiently follow-up for treatment, care and billing
- vii. To invoice for goods and services
- viii. To process credit card payments

When confirming appointments and returning your calls are we permitted to call and leave messages at:

Your Home- Yes \_\_\_\_\_ No \_\_\_\_\_

Your Work- Yes \_\_\_\_\_ No \_\_\_\_\_

Other, Please specify: \_\_\_\_\_

By signing the consent section of the Patient Consent Form, you have agreed that you have given your informed consent to Treatment and to the collection, use and/or disclosure of your personal information as outlined above.

**Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.**

**Client's Name \_\_\_\_\_**

**Parent/Guardian Signature \_\_\_\_\_**

**Carrie Meszaros, N.D. Signature \_\_\_\_\_ Date \_\_\_\_\_**