

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, craniosacral therapy 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.
169 Huron Street
Stratford, ON
N5A 5S9

Fee Schedule and Office Policies

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

** Prices listed do not include HST

Initial Consultation (1 hour)	\$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)	45.00
Initial Acupuncture and Consultation	70.00
Acupuncture + Short Consultation	70.00
Acupuncture without Consultation	55.00
Naturopathic Re-Assessment (after 18 months)	105.00
B12 Injection	12.00
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 \$25.00 for the appointment.** We understand that there are unforeseen events and circumstances and these of course will be taken into consideration. Our answering machine is available during off hours to take any messages. **A missed appointment with no notice will be charged \$35.00.**

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: _____

E-Mail Address: _____ Would you like our E-newsletter? _____

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

Phone: Home _____ Work _____ Height: _____ Weight: _____

How did you hear about this office? _____

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)

Hemphilus 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:

Gestational diabetes

High blood pressure

Thyroid conditions

Toxemia

Nausea and vomiting

Bleeding

Emotional trauma

Threatened miscarriage

Physical trauma

Other:

Were there any interventions during the birth (ie. 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 (ie.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:

Diaper rash

Seizures

Strep throat

Eczema

Whooping cough

Frequent colds

Frequent diarrhea

Asthma

Ear infections

Constipation

Psoriasis

Chicken pox

Cradle cap

Headaches

Measles

Cavities

Tummy aches

Mumps

Excess perspiration

Bedwetting

Rubella

Growing pains

Chronic nasal congestion

Joint problems

Bloody noses

Fecal incontinence

Insomnia

Motion sickness

Gas

Worms/parasites

Colic

Swollen glands

Allergies

Weight loss/ failure to grow

Fears (specify)

Bladder infections

Problems at school (specify)

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

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 and duration							

Diet/Activity Report: Please take the time to complete the 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.

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 comply 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 _____, 200 ____.

Client's Name _____

Parent/Guardian Signature _____

Carrie Meszaros, N.D Signature _____ **Date** _____