Bayview Chiropractic Health Centre
www.drmingaynd.com
(416) 481-7901
Dr. Elizabeth Mingay, ND

Adult Naturopathic Intake Form

Please take the time to fill out the forms below and bring them with you to your initial naturopathic appointment. Please try to be as accurate as possible. All information provided on these forms will be kept confidential.

Referred by: ____

Name: ____ Date: ____________

Date of Birth: ________________ Age: _____ Gender: M / F Other ______

Home Address: _____________________________________ Apt #: _________

City: _______________ Province: ____________ Postal Code: _____________

Email Address: ____

Phone: Home: _____________ Work: _____________ Cell:_____________

May we leave messages relating to visits? Y / N Which number? __________

Occupation(s): _____________________________________Full or Part Time?

Marital Status: ____

Children: Y / N If yes, list ages: ______________________________________

Emergency Contact: Name: ____

Phone Number(s): ___________________________Relation: ____________

Other health care providers you are seeing:

Name: _______________ Name: _______________ Name: _______________

Specialty: ____________ Specialty: ____________ Specialty: ____________

Phone: ______________ Phone: _______________ Phone: _______________

Date of last visit: _____ Date of last visit: ______ Date of last visit: ______

Have you ever consulted a naturopathic doctor / acupuncturist / nutritionist / counsellor before? (please circle)

Please rank your main health concerns in order of importance to you:

1. ____
2. ____
3. ____
4. ____
5. ____

How would you classify your current state of health (circle one):

Excellent Very Good Good Fair Poor

Comments ____

____

List any current diagnoses you have been given (if any) and when:

____

____

List names and doses of current medications and/or supplements (vitamins, homeopathics, herbs, other) that you are currently taking:

____

____

When was your most recent physical exam? Please provide the name and contact information of the practitioner.

____

____

Did you have blood work done? Y / N
Results (if known):
If unknown, please provide contact information for lab / blood work collection:

____

____

Past Medical History

List and briefly describe the nature of any known allergies (environmental, drugs, etc. but NOT foods):

____

____

List any hospitalizations and/or serious illnesses and approximate dates:

____

____

____

____

List any medications and/or supplements (vitamins, homeopathics, herbs, other) you have taken in the past (name and dosage if possible):

____

____

____

How was your health as a child?

As a teenager?

How many times have you been treated with antibiotics? _______________

Date of most recent antibiotic prescription? ___________________________

Please indicate what immunizations you have had:
□ DPT (diphtheria, petussis, tetanus)
□ Hepatitis A
□ Hepatitis B
□ MMR (measles, Mumps, rubella)
□ Haemophilus influenza B
□ "Flu"
□ Tetanus booster; when?___________
□ Small pox
□ Polio

Other:____

Please list any vaccination adverse reactions: __________________________

Lifestyle

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers: Y / N / P
Laxatives: Y / N / P Diet pills: Y / N / P
Antacids: Y / N / P
Birth control: Y / N / P Type (please circle) Pills / Implants / Injections
Alcohol—how much / day or week __________________________________
Tobacco—form and amount / day __________________________________
Are you exposed to a significant amount of tobacco smoke (home, work, etc.)? Y / N

Recreational drugs—what / how often________________________________
Caffeine—form and amount / day ____________________________________

Are you regularly exposed to animals (home, work, etc.)? Y / N
Are you regularly exposed to pesticides, solvents, heavy metals, fumes, or other toxic materials (home, work, hobbies, etc.)? Y / N
If yes, please describe: ____

Are you particularly sensitive to odours (perfumes, gasoline, other vapours such as new furniture, etc.)? Y / N

Average hours of sleep / night ____
What time do you go to bed?_________
What time do you wake?_________
Do you wake feeling rested? Y / N
How many times do you wake in the night on average? __________________
What is usually the reason for waking? _________________________________

Would you classify yourself as someone with difficulties sleeping? Y / N
If yes, please explain: ____

Do you:
nap during the day? Y / N
grind your teeth in your sleep? Y / N
snore? Y / N
have frequent nightmares? Y / N
sleep walk? Y / N

How many hours of exercise (on average) do you get / week? _____________
What type(s) of exercise do you do? ___________________________________

Do you belong to a gym? Y / N
If yes, how many days / week do you go? ______________________________

Please list any hobbies you may have: _______________________________

____

Please rate your average energy on a scale of 1-10 (1 = no energy, 10 = full of energy): __________

What time of day are you most energetic?________

Least energetic?________

Have you ever felt that you don't have enough energy to complete daily tasks? Y / N

If yes, how often (please circle): Rarely Sometimes Often Daily

How stressful is your home environment on a scale of 1-10 (1 = not at all stressful, 10 = extremely stressful) and why?

____

____

____

Please respond to the above question as it pertains to your work environment (if applicable):

____

____

____

Are there any other aspects of your life that cause you major stress?

____

____

____

How many meals do you consume / day? _____________________________

What foods do you crave? ____

Any food aversions? ____

Generally, how is your appetite? ____________________________________

____

Please list and identify any foods that you are sensitive (S) or allergic (A) to and what symptoms you experience:

____

____

____

____

Do you maintain any specific dietary regimes (vegetarian, vegan, religious, other)? ____

Please describe a typical daily diet:
Breakfast: ____
Snack: ____
Lunch: ____
Snack: ____
Dinner: ____
Other (pop, candy, etc.): _______________________________
Water consumed: _______________________________________

Do you cook most of your own meals? Y / N
If no, where do you get the majority of your meals? ______________

____
How many times a week do you eat out at a restaurant? ______________

Do you consider your diet healthy? Y / N
What about your diet would you like to see improve? ________________

____

Do you sit down to consume the majority of your meals? Y / N

Family Health History

Please indicate below if any member(s) of your family has had any of the following health problems:

Health Problem	Relationship to Patient (can be self)	Age of Onset	Duration of Illness	Deceased? (Y / N) and Cause of Death
Alcoholism / drug addiction				
Allergies				

Arthritis				
Asthma				
Autoimmune disease (e.g. RA, Lupus)				
Cancer				
Depression / other mental illness				
Diabetes				
Eczema				
Epilepsy				
Heart problems				
High blood pressure				
Osteoporosis				
Stroke				
Thyroid issues				
Other				

Review of Systems

Present weight: ___________ Height: ___________
Weight 1 year ago: ___________
Maximum weight: ___________ Minimum weight (adult):___________
Ideal weight: ___________
Have you ever struggled with your weight? Y / N

Please fill out the chart below regarding your *bowel movements*:

Frequency		**Consistency (typically)**	
More than 3x/day		Soft and well formed	
1-3x/day		Loose but not watery	
4-6x/week		Diarrhea	
2-3x/week		Thin, long, or narrow	
1 or fewer x/week		Small and hard	
		Difficult to pass	
Colour (typically)		Often float	
Yellow / light brown		Alternates between hard and loose / watery	
Medium brown		Undigested food	
Dark brown			
Very dark / black			
Varies a lot			
Green(ish)			
Visible blood (in stool)			
Visible blood (on toilet paper only)			
Greasy / shiny appearance			

For each section below, please circle **Y** if you are currently experiencing this symptom, **N** if you have never experienced the symptom, and **P** if you have experienced the symptom in the past. Please also provide a brief description if you select **Y** or **P**.
This section is lengthy and will take some time to fill out, however it is important in order to obtain a complete picture of your health.

Digestion	**Circle One**	**Description**
Heartburn	Y N P	
Belching	Y N P	
Gas	Y N P	
Bloating	Y N P	
Upper abdominal pain	Y N P	
Lower abdominal pain	Y N P	
Nausea	Y N P	
Vomiting	Y N P	

Canker sores	Y N P	
Constipation	Y N P	
Diarrhea	Y N P	
Hemorrhoids	Y N P	
Fissures	Y N P	
Strong stool odour	Y N P	
Mucus in stool	Y N P	
Lactose intolerance	Y N P	
Gluten intolerance	Y N P	
Change in appetite	Y N P	
Other:		
Pancreatitis	Y N P	
Ulcer (peptic or duodenal – please specify)	Y N P	
Gallstones	Y N P	
Gall bladder disease	Y N P	
Liver disease	Y N P	
Splenectomy	Y N P	
Appendectomy	Y N P	

Skin	**Circle One**	**Description**
Acne	Y N P	
Rash	Y N P	
Eczema	Y N P	
Hives	Y N P	
Shingles	Y N P	
Psoriasis	Y N P	
Dry skin	Y N P	
Oily skin	Y N P	
Peeling skin	Y N P	
Itchy skin	Y N P	
Lump(s)	Y N P	

Sensitive to insect bites	Y	N	P	
Red face	Y	N	P	
Skin darkening	Y	N	P	
Skin lightening	Y	N	P	
Vitiligo	Y	N	P	
Thick calluses	Y	N	P	
Athlete's foot	Y	N	P	
Jock itch	Y	N	P	
Herpes - oral	Y	N	P	
Herpes - genital	Y	N	P	
Easy bruising	Y	N	P	
Dark circles underneath eyes	Y	N	P	
Night sweats	Y	N	P	
Fever	Y	N	P	
Flushing	Y	N	P	
Heat intolerance	Y	N	P	
Cold intolerance	Y	N	P	
Cold hands & feet	Y	N	P	
Strong body odour	Y	N	P	
Moles w/ colour/size change	Y	N	P	
Warts	Y	N	P	
Skin cancer	Y	N	P	
Nail changes	Y	N	P	

Head	**Circle One**			**Description**
Dandruff	Y	N	P	
Dry hair	Y	N	P	
Oily hair	Y	N	P	
Itchy scalp	Y	N	P	
Hair loss	Y	N	P	
Psoriasis	Y	N	P	
Headache	Y	N	P	

Migraine	Y	N	P	
Head Injury	Y	N	P	
Dizziness	Y	N	P	
Enlarged lymph nodes (neck)	Y	N	P	
Tender lymph nodes (neck)	Y	N	P	

Eyes	**Circle One**			**Description**
Eye pain	Y	N	P	
Eye crusting	Y	N	P	
Itchy eyes	Y	N	P	
Conjunctivitis	Y	N	P	
Excessive tearing	Y	N	P	
Eye (white) discharge	Y	N	P	
Dry eyes	Y	N	P	
Vision loss	Y	N	P	
Double vision	Y	N	P	
Glaucoma	Y	N	P	
Cataracts	Y	N	P	
Macular degeneration	Y	N	P	
Sty	Y	N	P	
Corrective lenses	Y	N	P	

Ears	**Circle One**			**Description**
Ear pain	Y	N	P	
Ear fullness	Y	N	P	
Itchy ears	Y	N	P	
Ear infection	Y	N	P	
Hearing problems	Y	N	P	
Ear discharge	Y	N	P	

Sensitive to loud noises	Y N P	
Ear ringing/buzzing	Y N P	
Redness	Y N P	

Mouth & Nose	**Circle One**	**Description**
Dry mouth	Y N P	
Bad breath	Y N P	
Gingivitis	Y N P	
Sore throat	Y N P	
Loss of taste	Y N P	
Tooth decay	Y N P	
Dentures	Y N P	
Cavities	Y N P	
Hoarseness	Y N P	
Dry nose	Y N P	
Nosebleeds	Y N P	
Post nasal drip	Y N P	
Congestion	Y N P	
Polyps	Y N P	
Seasonal allergies	Y N P	
Sinus infections	Y N P	

Respiratory	**Circle One**	**Description**
Cough - dry	Y N P	
Cough - wet	Y N P	
Wheezing	Y N P	
Asthma	Y N P	
Pneumonia	Y N P	
Bronchitis	Y N P	
Shortness of breath @ sitting	Y N P	
Shortness of breath lying	Y N P	

Shortness of breath on exertion	Y N P	
Cough w/ blood	Y N P	
Tuberculosis	Y N P	
Painful breathing	Y N P	

Cardiovascular	Circle One	Description
Heart palpitations	Y N P	
Atherosclerosis	Y N P	
Chest pain	Y N P	
Arrythmia	Y N P	
High blood pressure	Y N P	
Low blood pressure	Y N P	
Heart murmur	Y N P	
Edema (swelling)	Y N P	
Varicose veins	Y N P	
Blood clot	Y N P	
Rheumatic fever	Y N P	
Heart attack	Y N P	
Breathlessness	Y N P	
Irregular pulse	Y N P	

Urinary	**Circle One**	**Description**
Hesitancy	Y N P	
Urgency	Y N P	
Incontinence/ leaking	Y N P	
Bed wetting	Y N P	
Infection	Y N P	
Kidney stone	Y N P	
Kidney disease	Y N P	

Pain	Y	N	P	
Burning	Y	N	P	
Strong odour	Y	N	P	
Dark yellow	Y	N	P	
Pale yellow	Y	N	P	
Blood in urine	Y	N	P	
Discharge in urine	Y	N	P	

Female Reproductive	**Circle One**			**Description**
Age period began				
Age period ceased (if applicable)				
Frequency of period				
Length of period				
Around menses:				
Fatigue	Y	N	P	
Cramping	Y	N	P	
Bloating	Y	N	P	
Mood swings	Y	N	P	
Loose stools	Y	N	P	
Constipation	Y	N	P	
Carbohydrate craving	Y	N	P	
Chocolate craving	Y	N	P	
Increased sleep	Y	N	P	
Decreased sleep	Y	N	P	
Breast tenderness	Y	N	P	
Heavy bleeding	Y	N	P	

Scanty bleeding	Y	N	P	
Irregular periods	Y	N	P	
No periods	Y	N	P	
General:				
Breast cysts	Y	N	P	
Breast lumps	Y	N	P	
Breast cancer	Y	N	P	
Mammography (date & results)	Y	N	P	
Nipple discharge	Y	N	P	
Menopause at what age				
Vaginal dryness	Y	N	P	
Vaginal discharge	Y	N	P	
Vaginal itching	Y	N	P	
Vaginal odour	Y	N	P	
Vaginal pain	Y	N	P	
Bleeding during or after intercourse	Y	N	P	
Pain during intercourse	Y	N	P	
Bleeding between periods	Y	N	P	
# of Births				
# of Miscarriages				
# of Abortions				
Ovarian cyst	Y	N	P	
Fibroids	Y	N	P	
Endometriosis	Y	N	P	
Infertility	Y	N	P	
Poor libido	Y	N	P	
Last Pap smear				
Abnormal Pap	Y	N	P	
Use of hormones	Y	N	P	

Type of hormones used		
Sexually transmitted infection	Y N P	
Sexually active	Y N P	
Vaginitis	Y N P	
Yeast infections	Y N P	
Bone density test (date & results)	Y N P	
Other		

Male Reproductive	Circle One	Description
Infection of penis	Y N P	
Impotence	Y N P	
Incontinence/ leaking	Y N P	
Bed wetting	Y N P	
Lumps in testicles	Y N P	
Testicular pain / swelling	Y N P	
Prostate infection	Y N P	
Prostate enlargement	Y N P	
Penile discharge	Y N P	
Ejaculation problem	Y N P	
Genital pain	Y N P	
Hernia	Y N P	
Poor libido	Y N P	
Sexually active	Y N P	
Sexually transmitted infection	Y N P	

Last Digital Rectal Exam		
Last PSA test & results		
Other		

Musculoskeletal	Circle One	Description
Joint pain	Y N P	
Joint redness	Y N P	
Joint inflammation	Y N P	
Joint stiffness	Y N P	
Muscle pain	Y N P	
Muscle inflammation	Y N P	
Muscle spasms	Y N P	
Muscle weakness	Y N P	
Muscle stiffness	Y N P	
Muscle twitches	Y N P	
Muscle tremors	Y N P	
Calf cramps	Y N P	
Foot cramps	Y N P	
Tendonitis	Y N P	
Osteoarthritis	Y N P	
Rheumatoid arthritis	Y N P	
TMJ problems	Y N P	

Nervous System	Circle One	Description
Numbness	Y N P	
Tingling	Y N P	
Sciatica	Y N P	
Fainting	Y N P	
Carpal Tunnel Syndrome	Y N P	
Seizures	Y N P	

Paralysis	Y	N	P	
Multiple Sclerosis	Y	N	P	
Lupus	Y	N	P	
Other	Y	N	P	

Mental/Emotional	**Circle One**			**Description**
Anxiety	Y	N	P	
Panic attacks	Y	N	P	
Paranoia	Y	N	P	
Anger issues	Y	N	P	
Depression	Y	N	P	
Suicidal thoughts	Y	N	P	
Attempted suicide	Y	N	P	
Irritability	Y	N	P	
Phobias	Y	N	P	
Hallucinations	Y	N	P	
High-strung/tense	Y	N	P	
Anorexia nervosa	Y	N	P	
Bulimia	Y	N	P	
Binge eating	Y	N	P	
Psych hospitalization	Y	N	P	

Informed Consent

Naturopathic medicine is the treatment of illness through the use of natural and non-invasive measures that stimulate the body to heal itself from within. Your ND will take you through a thorough intake, a complete physical exam, and provide you with appropriate and effective treatment plans by the conclusion of the second visit.

It is crucial that you provide your ND with a detailed and accurate medical history, as well as a complete list of any pharmaceutical medications and/or supplements that you are currently taking. Advising your ND of any allergies to medications and/or foods is also very important.

Your signature must be obtained prior to beginning treatment, acknowledging the statements below:

- You have read the above information and that you understand that you are ultimately responsible for your own health.
- Diagnosis, treatment and/or referral to other health care professionals are based upon the assessment of conditions revealed through personal history, interview, physical assessment and laboratory testing.
- You have been informed of, and understand the diagnostic and therapeutic procedures with respect to expected benefits, potential risks and side effects, the likely consequences of not having/following the procedure(s) and what alternative course(s) of action are available.
- You are accepting or rejecting this care of your own free will and choice.
- You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered (by the end of each visit).
- If you have any questions regarding your treatment program, you will call to clarify these issues.

Patient name (please print): ____

Signature of Patient or Guardian: ___________________ Date: __________

Patient Consent Form For Collection Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our policy, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy ensures that:

- only necessary information is collected about you
- our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy
- we only share your information with your consent
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

We understand the importance of protecting your personal information. To help you understand how we are doing so, we have outlined below how our clinic will use and disclose your information. This clinic will collect, use and disclose information about you for the following purposes:

- to assess your health concerns
- to provide health care
- to advise you of treatment options
- to establish and maintain contact with you
- to remind you of upcoming appointments
- to communicate with other treating health-care providers
- to allow us to efficiently follow-up for treatment, care and billing
- to complete claims for insurance purposes
- to comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act
- to invoice for goods and services
- to process credit card payments

• to collect unpaid accounts
• to assist this clinic to comply with all regulatory
requirements
• to comply generally with the law
• to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

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

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information. I agree that Dr. Elizabeth Mingay, ND can collect, use and disclose personal information about___________________________(patient name) as set out above in the information about the clinic's privacy policies.

Patient signature____________________________________

Date__________Signature of witness_______________________________

Naturopathic Fee Schedule

Adult Consultations:

Initial Visit (60-75 mins)	$195
Acupuncture Visit (40 mins)	$110
Follow-up Visit (30 mins)	$80

Pediatric/Adolescent Consultations (under 18 years):

Initial Visit (60-75 mins)	$175
Follow-up Visit (30 mins)	$70

IV Therapy, Injections, Other:

IV Drip	$140
High Dose Vitamin C IV Drip	$180
B12 Injection	$30 + hst
Telephone consultations	$75
Seasonal Allergy Testing	$100

Cosmetic Acupuncture

* Initial Visit (90 mins)	$195
Cosmetic Follow-up (90 mins)	$140
Maintenance Follow-up (60 mins)	$100

* Initial visits include a 45-minute medical intake and a 45-minute introductory cosmetic acupuncture treatment.
For best results, we recommend 12 sessions.

- Fees are to be paid at the end of each visit
- All fees are subject to HST (13%)
- Botanical, homeopathic, and/or supplement prescriptions are not included in the above fee

Naturopathic appointments are not covered by OHIP, however they are covered in many extended health care plans. We recommend that you keep your receipt(s) and consult your insurer.

Please sign and date below, indicating you will abide by and understand all of the information above:

Signature:______________________________ Date:_________________

IV Therapy Consent Form

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by the naturopathic physician, Dr. Elizabeth Mingay, ND at Bayview Chiropractic Health Centre.

(Initials)_____ I have informed the naturopathic physician of any known allergies to drugs or other substances, or of any past reactions to anesthetics.
I have informed the doctor of all current medications and supplements.
I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

I understand that:
1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:
a. Occasionally to commonly:
i. Discomfort, bruising and pain at the site of injection.
b. Rarely:
i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
c. Extremely Rarely:
i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
d. Benefits of intravenous therapy include:
i. Injectables are not affected by stomach, or intestinal absorption problems.
ii. Total amount of infusion is available to the tissues.
iii. Nutrients are forced into cells by means of a high concentration gradient.
iv. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseeable complications could occur. I do not expect the naturopathic physician(s) to anticipate and or explain all risk and possible complications. I rely on the physician(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.
I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV therapy with any different or further procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

My signature below confirms that:
1. I understand the information provided on this form and agree to the foregoing.
2. The procedure(s) set forth above has been adequately explained to me by my naturopathic physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of the procedure(s).

_________________________________ ______________________
Patient's Name – Please Print Date

_________________________________ ______________________
Patient's Signature Date

_________________________________ ______________________
Physician's Name – Please Print Date

_________________________________ ______________________
Physician's Signature Date