

BAYIEW NATUROPATHIC WELLNESS

Dr. Kitty Shang BSc, ND, Doula

16860 Bayview Avenue
Newmarket, ON L3Y 3W8
(905) 235-5168

Date _____

Name _____

Address _____

City _____ Province _____ Postal Code _____

Home # _____ Work # _____ Cell # _____

Email _____

Date of Birth _____ Present Age _____ Blood Type _____

Occupation _____

Marital Status _____ Name of Spouse/Partner _____

of children and details (age, gender, name) _____

Health Care Practitioner _____

Address _____

Telephone _____

Who referred you to this office _____

Dear Patient,

Congratulations on choosing naturopathic medicine. You have taken the first step towards a healthier you. This detailed intake form will help your naturopathic practitioner to make effective conclusions about your overall health and the best way to improve it. It is important that you complete this questionnaire honestly and accurately. Your naturopathic doctor is the only person who will review this survey and your confidentiality is strictly maintained. If you have questions or concerns about this questionnaire, please call the office and we will help you to decide how best to solve the issue.

Please be sensitive to the fact that some people are not able to tolerate the odour of cigarettes, perfume, cologne, or after-shave lotions. Please come to our office smoke and fragrance free. We appreciate your attendance to this. Thank you.

Fee Schedule

Initial Consultation (1 hour 30 Minutes)	\$ 185 + tax
Second Visit (45 Minutes)	\$ 105 + tax
Follow up Visits (typically 30 Minutes)	\$ 150/ hour + tax (\$75 for 30 minutes)
Telephone appointments (Max 20 Minutes)	Varies with amount of time spent
Acupuncture or Bowen Treatment (45 Minutes)	\$70 + tax
Optional Laboratory Testing	
Hair Analysis for Heavy Metal	\$75.00 + tax
Ig G Food Allergy Testing	Varies \$220- 310 + tax
Salivary Hormone Testing (female panel, male panel, cortisol level)	Varies
Other Laboratory Tests also available	
NSF cheques	\$10.00
Medical – legal reports	Varies with amount of time spent

A 10% discount is offered to:

- Seniors (65+)
- Full-time under-graduate students
- Families (more than 2 members)

Confidential Patient Information

1. What is your present Height _____
Weight _____
Date of latest measurement _____

2. Has your weight changed over the past year? Yes _____ No _____
If yes, please offer an explanation _____

3. What is your reason for attending this office? Please be prepared to describe your condition in great detail during your naturopathic medical interview. Make note of symptoms you typically experience, other people's observation, and any factors which may have contributed to the condition's onset / development?

4. If this is a chronic illness, how long have you had this condition? _____
Who diagnosed your illness? _____
When was this diagnosis made? _____
What specialists have you seen and when? _____

5. How has this illness been treated until now, and what results have been obtained to date?

6. What other objectives do you have as far as your health is concerned? If these objectives are related to specific health conditions, then also advise as to how long these conditions have existed.

7. How long has it been since you were totally well? _____

8. Are you currently working with a professional counselor, psychologist, social worker, or other therapist? Please provide details

9. Have you had naturopathic treatment before? Please provide details

Each line below represents a year in your life. Please draw a timeline of all major events in your life. This will enable your naturopathic doctor to assess your present health problems. Please indicate in chronological order all accidents, illnesses, hospitalizations, surgery, injuries, traumatic and emotional events, major changes in your life up to this point in time. Also, please include when you had vaccinations, you started school, changes schools, graduated, failed, got married, had children, separated, divorced, etc. We want to know about all MAJOR TRAUMAS which may have impacted on your life at a MENTAL, EMOTIONAL or PHYSICAL level. Please circle the top 5 stressful events.

Age 1 _____

Age 2 _____

Age 3 _____

Age 4 _____
Age 5 _____
Age 6 _____
Age 7 _____
Age 8 _____
Age 9 _____
Age 10 _____
Age 11 _____
Age 12 _____
Age 13 _____
Age 14 _____
Age 15 _____
Age 16 _____
Age 17 _____
Age 18 _____
Age 19 _____
Age 20 _____
Age 21 _____
Age 22 _____
Age 23 _____
Age 24 _____
Age 25 _____
Age 26 _____
Age 27 _____
Age 28 _____
Age 29 _____
Age 30 _____
Age 31 _____
Age 32 _____
Age 33 _____
Age 34 _____
Age 35 _____
Age 36 _____
Age 37 _____
Age 38 _____
Age 39 _____
Age 40 _____
Age 41 _____
Age 42 _____
Age 43 _____
Age 44 _____
Age 45 _____
Age 46 _____
Age 47 _____
Age 48 _____
Age 49 _____

Age 50 _____
Age 51 _____
Age 52 _____
Age 53 _____
Age 54 _____
Age 55 _____
Age 56 _____
Age 57 _____
Age 58 _____
Age 59 _____
Age 60 _____
Age 61 _____
Age 62 _____
Age 63 _____
Age 64 _____
Age 65 _____
Age 66 _____
Age 67 _____
Age 68 _____
Age 69 _____
Age 70 _____
Age 71 _____
Age 72 _____
Age 73 _____
Age 74 _____
Age 75 _____
Age 76 _____
Age 77 _____
Age 78 _____
Age 79 _____
Age 80 _____
Age 81 _____
Age 82 _____
Age 83 _____
Age 84 _____
Age 85 _____
Age 86 _____
Age 87 _____
Age 88 _____
Age 89 _____
Age 90 _____

Family Health History

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER AILMENTS, HAVE AFFECTED YOUR RELATIVES:

Alcoholism	Asthma	Digestive Disorders	Hay Fever	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Heart Disease	Paralysis	Syphilis
Alzheimer's	Depression	Gonorrhea	Hypertension	Parkinson's	Thyroid Disorder
Arthritis	Diabetes	Gout	Kidney Disease	Pneumonia	Tuberculosis

RELATIVE	AGE if alive	AGE if death	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

REVIEW OF SYMPTOMS

Please circle "Y" if you have the condition now and "P" if you had it in the past

SKIN:

Rashes	Y	P
Hives	Y	P
Acne	Y	P
Boils	Y	P
Eczema	Y	P
Psoriasis	Y	P
Dry skin	Y	P
Itching	Y	P
Lumps	Y	P
Night sweats	Y	P
How often		
Other _____		

MOUTH & THROAT:

Hoarseness	Y	P
Gum Problems	Y	P
Dental cavities	Y	P
Sores	Y	P
Mouth Dryness	Y	P
Sore throats	Y	P
Lose taste	Y	P
Other _____		

RESPIRATORY:

Wheezing	Y	P
Coughing	Y	P
Breath short	Y	P
Difficult breath	Y	P
Chest pain	Y	P
Bloody sputum	Y	P
Emphysema	Y	P
Asthma	Y	P
Breath painful	Y	P
Bronchitis	Y	P
Pneumonia	Y	P
Pleurisy	Y	P
Last chest ray	Y	P
Last TB test	Y	P
Other _____		

GASTROINTESTINAL:

Heartburn	Y	P
Difficult swallow	Y	P
Thirst changes	Y	P
Appetite changes	Y	P
Nausea	Y	P
Indigestion	Y	P
Gas/belching	Y	P
Constipation	Y	P
Rectal bleeding	Y	P
Hemorrhoids	Y	P

Jaundice	Y	P
Hernias	Y	P
Diarrhea	Y	P
No. BM/day		

HEAD:

Headache	Y	P
Migraine	Y	P
Dizziness	Y	P
Injuries	Y	P
Other _____		

NECK:

Pain	Y	P
Swollen glands	Y	P
Lumps	Y	P
Goiter	Y	P
Stiffness	Y	P
Other _____		

NOSE AND SINUSES:

Bleeding	Y	P
Stuffiness	Y	P
Hayfever	Y	P
Injuries	Y	P
Colds	Y	P
Allergies	Y	P
Obstruction	Y	P
Sinus problems	Y	P
Other _____		

CARDIOVASCULAR:

Heart disease	Y	P
Angina	Y	P
High blood pres.	Y	P
Murmurs	Y	P
Chest pain	Y	P
Palpitations	Y	P
Ankle swelling	Y	P
Rheumatic fever	Y	P
Last ECG test	Y	P
Other _____		

URINARY:

Pain urinating	Y	P
More frequent	Y	P
Reduced flow	Y	P
Kidney stones	Y	P
Blood in urine	Y	P
Infections	Y	P
Incontinence	Y	P
Other _____		

EYES:

Impaired vision	Y	P
Pain	Y	P
Redness	Y	P
Double vision	Y	P
Cataracts	Y	P
Light sensitive	Y	P
Discharge	Y	P
Tearing	Y	P
Dryness	Y	P
Itching	Y	P
Blurring	Y	P
Glaucoma	Y	P
Blind spot(s)	Y	P
Contact lenses	Y	P
Other _____		

EARS:

Discharge	Y	P
Itching	Y	P
Excess wax	Y	P
Infection	Y	P
ringing	Y	P
Earache	Y	P
Hearing loss	Y	P
Other _____		

BREASTS:

Lumps	Y	P
Tenderness	Y	P
Self examine?	Y	P
Other _____		

PERIPHERAL VASCULAR

Cold hands/feet	Y	P
Deep leg pain	Y	P
Varicose veins	Y	P
Thrombophlebitis	Y	P
Other _____		

MUSCULOSKELETAL:

Joint pain	Y	P
Arthritis	Y	P
Broken bones	Y	P
Numbness	Y	P
Tingling	Y	P
Muscle spasms	Y	P
Weakness	Y	P
Backache	Y	P
Other _____		

FEMALES:

Age of first menses _____
 Menopause symptoms Y P
 Age _____
 Type of birth control _____
 How long? _____
 Last pap _____
 Vaginal discharge Y P
 Vaginal itching Y P
 Other _____

MENSES:

Cycle regular YES NO
 Length of cycle
 Bleeding between periods Y P
 Painful menses Y P
 Excessive flow Y P
 No. of pregnancies
 Age
 No. of miscarriages
 No. of abortions

PMS SYMPTOMS:

Depression Y P
 Bloating Y P
 Increased appetite Y P
 Weight gain Y P
 Breast tenderness Y P
 Other _____

REPRODUCTIVE:

Sexual difficulties Y P
 Venereal disease Y P

MALE:

Prostate symptoms Y P
 Impotence Y P
 Testicular masses Y P
 Hernia Y P
 Urgency of urination Y P
 Incomplete urination/dribbling Y P
 Decreased sexual desire Y P

BLOOD/LYMPHATIC:

Anemia Y P
 Swollen lymphs Y P
 Easy bleeding Y P
 Bruising Y P
 Transfusions Y P
 Clotting Y P
 Other _____

ENDOCRINE:

Thyroid problems Y P
 Diabetes Y P
 Hypoglycemia Y P
 Hormone therapy Y P
 Other _____

NEUROLOGICAL

Fainting Y P
 Seizures Y P
 Convulsions Y P
 Paralysis Y P
 Muscle weakness Y P
 Memory loss Y P
 Involuntary movements Y P
 Loss of balance Y P
 Speech problems Y P
 Other _____

PSYCHO/SOCIAL

Depression Y P
 Tension Y P
 Mood swings Y P
 Phobias Y P
 Sleep problems Y P
 Anxiety Y P
 Nervousness Y P
 Alcohol or drug abuse Y P
 Other _____

ADRENAL:

Fatigue, apathy Y P
 Allergies Y P
 Delayed wound healing Y P
 Low blood pressure Y P
 Dizziness when standing up Y P
 Frequent urination Y P
 Urination at night Y P
 Muscular weakness Y P
 Nervousness Y P
 Low back pain Y P
 Knee pain Y P
 Ringing in the ears Y P

THYROID:

Loss of hair Y P
 Weight gain Y P
 Dry skin Y P
 Loss of outer part of eyebrows Y P
 Menstrual disorders Y P

Stubborn constipation Y P
 Goiter Y P
 Low or high blood Cholesterol Y P
 Feeling very cold Y P

LIVER:

Anemia Y P
 Hypertension Y P
 Elevated blood cholesterol Y P
 Low energy before eating Y P
 Decreased drug or alcohol tolerance Y P
 Premenstrual tension Y P
 Endometriosis Y P
 Heavy menses Y P
 Frequent headaches Y P
 Skin problems Y P
 Constipation Y P
 Gall bladder problems Y P
 Chronic muscle tension Y P
 Eye problems Y P
 Difficulty digesting fatty foods Y P

PANCREAS:

Food allergies Y P
 Blood sugar abnormalities Y P
 Maldigestion Y P
 Undigested food in stool Y P
 Bowel gas Y P
 Stool floats Y P

PARATHYROID:

Osteoporosis Y P
 Joint pain Y P
 Gum/tooth disease Y P
 Kidney stones Y P
 Ridged fingernails Y P
