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 _____

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 _____
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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 AFFECTEDYOUR 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
Pnemonia	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 vison	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:

	YES	NO
Cycle regular		
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

Naturopathic Fee Schedule

(Effective January 30 2014)

Initial Adult Consultation (up to 1.5 hr)	$200
Second Adult Consultation (up to 45 min)	$115
Follow Up Adult Consultation ($85 for 30 min)	$170/ hr
Initial Body Work Consultation (1.5 hr, include 30 min treatment)	$115
Body Work Follow Up Treatments (45 minutes)	$ 77
Body Work Follow Up Treatment Package (average to $67 per treatment)	$335 for 5 treatments
Initial Pediatric Consultation (up to 1.5 hr)	$115
Pediatric Follow Up Consultation Children 3 yrs and under (e.g. $50 for 30 min) Children 4-12 yrs (e.g. $70 for 30 min)	 $100/ hr $140/ hr
Initial IV Consultation (up to 60 min)	$115
IV Treatments	$85 or more
Birthing Doula: 2 prenatal, labour/delivery, 2 postnatal ($300 under mother's name, $300 under baby's name)	$600
Senior (65+) Discount	10% off all consultation & body work treatment fee
Phone/Email (up to 15 minutes)	Hourly rate
Food & Symptom Diary Quick Analysis	$14/week