PATIENT CONSENT & ACKNOWLEDGEMENT

I, the undersigned, hereby acknowledge that I am here, on this and any subsequent visit, solely on my own behalf.
I hereby acknowledge and understand that Maureen Fontaine is a not medical practitioner and in particular:

1. Is not presenting herself as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, disability or physical condition;
2. Is not offering to undertake by any means or method to diagnose, treat, operate, or prescribe for any human disease, pain, injury, disability or physical condition; and
3. Cannot and will not give medical advice.

I hereby confirm and acknowledge that all information from, or, communication with Maureen Fontaine is at my own request, with full knowledge of the particulars; and that no guarantees have been made to me concerning the results that may be obtained.

All information is held in the strictest confidence and is for the sole purpose of this session only.

Date: ________________________ 20____ . Signature ____________________________________

PRIOR TO APPT: (1) NO food for *3 hours* (2) Avoid Coffee (3) Drink plenty of water.

Last Name ___________________________________ First Name _________________________________

Address ____ City ____________ Postal Code __________

Email ____

Phone ____ Cell ____________________________________

Age _________ Height _________ Weight _________ Date of Birth______________________________

Occupation ____ Children (#) _____ Marital Status _____

Primary Concerns: (1) ____

(2) ____ (3) _______________________________________

I am presently receiving care from a/an:

___ Medical Doctor ___ Massage Therapist ___ Naturopath ___ Acupuncturist
___ Chiropractor ___ Personal Trainer ___ Nutritionist ___ Other ___________________

Medications: ____

Supplements: ____

Surgeries: ____

Exercise includes: ____ Times per week ________

Motor Vehicle Accidents or Significant Injuries: ____

Energy Level: ___/10 Stress level ___ /10 Self Discipline: ____/10 Commitment to Health ___/10

BLOOD TYPE ____

Continue to other side ➔

Current symptoms & concerns

Digestive System/GI
_ Gas _ Bloating
_ Constipation
_ Loose stool _ Diarrhea
_ Crohn's _Celiac _ IBS
_ Hemorrhoids _ Bleeding
_ Oily or smelly stools
_ Stomach pain
_ Ulcers
_ Nausea _ Burping
_ Acid Reflux/Heartburn
_ Parasites
_ Hunger: __never __always

Daily Bowel Movements ___

Urinary System
_ Frequent urination
_ Painful/burning urination
_ Bladder/kidney infections

Vascular System
_ Heart Pain/Tremors
_ Heart Pounds/Palpitations
_ Dizziness __Shaky
_ High Blood Pressure
_ Low Blood Pressure
_ High Cholesterol
_ Bruise easily

Endocrine System
_ Fatigue _ Exhaustion
_ Brittle fingernails
_ Hair falling out
_ Low sex drive
_ Weight gain _ loss
_ Crave Salt _ Sugar
_ Feel Cold _ Feel Hot

Brain
_ Poor memory
_ Fuzzy thinking/mental fog

Thyroid Condition
_ Hyper _ Hypo
_ Other: ________________

Diabetic
Diagnoses _Type 1 _Type 2
_ Pre-diabetic
_ Sweaty palms, feet
_ Sweat a lot __ Don't sweat

Emotional/Spiritual
_ Depression
_ Low Self Esteem
_ Mood Swings
_ Poor Sleep
_ Anxiety / Panic Attacks

Respiratory System
_ Shortness of Breath
_ Asthma __Allergies
_ Colds
_ Yawning/sighing
_ Clear throat frequently
_ Sore throat frequently
_ Phlegm, nasal drip
_ Itchy ears

Smoking - Addictions
_ Tobacco ___ #/day
for ___ years
_ Marijuana ___ x wk
_ Other Recreational drugs
_ I am addicted to ________.

Muscular/Skeletal System
_ Muscle/Joint Pain _Cramps
_ Fibromyalgia _ Arthritis
_ Osteo ______________
_ Headaches __ x/ mth.

Immune System
_ CANCER current or past
Type: ______________
_ HIV/Hepatitis
_ Cold sores
_ Genital Herpes
_ Fungal Infections __toes
_ Lymph nodes swollen
_ Metallic taste in mouth

Skin
_ Eczema _ Psoriasis
_ Dry _ Oily _ Fungus
_ Warts/Moles
_ Acne

Women Only
Days since last period _____
_ Heavy _Light _Clots
_ PMS _ Birth Control
_ Pregnant __ Breastfeeding
_ Infertility issues
_ Menopausal since
_ HRT
_ Cysts, fibroids
_ Breast augmentation
_ Breast tenderness
_ Mastectomy
_ Low Libido
_ Vaginal Dryness
_ C-section x ___

Men Only
_ Prostate issues
_ Jock Itch
_ Low Libido
_ Erectile Dysfunction

Dental
_ Amalgam (silver) fillings
_ Crowns _ Root Canals
_ Bridges/Dentures

Sleep
_ Trouble falling asleep
_ Wake up through night
_ Dream disturbed
_ Night sweats
_ Not refreshed

DIET

Check those that apply to you.

__ Vegetarian __ Vegan
__ Animal Protein __ Eggs
__ Vegetables: __ steamed __ raw
__ Coffee __Tea __ Water
__ Dairy: cheese, milk, yogurt
__ Fermented foods, kefir, etc.
__ Fruit __ Fruit Juice
__ Wheat /Grain __ Gluten Free
__ Soy Products
__ Salt __ Sugar
__ Honey/Maple Syrup/Agave
__ Artificial Sweeteners
__ Nuts __ Seeds
__ Soft Drinks __ Energy Drinks
__ Alcohol, Drinks/ wk ____