# PATIENT INTAKE FORM

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 these sessions only.

***I give permission for any photos gathered to be used anonymously for teaching purposes. Initial here. X_____***

**Date: _____ 20____ . Signature _____**

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

Last Name _____ First Name _____

City _____ Postal Code _____ Email _____

Best Phone Number: _____ Date of Birth_____ Height ____ Weight ____

Occupation _____ Children (#) ___ Marital Status _____ **BLOOD TYPE** _____

**Primary Concerns: (**1) _____

(2) _____ (3) _____

I am presently receiving care from:

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

Medications: _____

Supplements: _____

Surgeries: _____

Exercise includes: _____ x per week __. "Please don't' make me exercise." __

Motor Vehicle Accidents or Significant Injuries: _____

**RATE out of 10:**

Energy __ Stress __ Self-Discipline __ Commitment to Health __ Happiness: work__ personal __

*"I heard about you via: __friend, __social media, __web, __other."*

Who might I thank for sending you? _____

**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

**Bowels**
Movements per day x_____
Color: _____
Form: _____

**Urinary System**
_ Always have to urinate
_ Painful/burning urination
_ Bladder/kidney infections
_ Incontinence

**Vascular System**
_ Heart Pain
_ Heart Pounds _Palpitations
_ Skips a beat _Throbs
_ Dizzy _Shaky _Tremors
_ Internally vibrating
_ Blood pressure: _↑ _↓
_ Cholesterol: _↑ _↓
_ Bruise easily
_Varicose veins: _____

**Endocrine System**
_ Fatigue _ Exhaustion
_ Brittle fingernails
_ Hair falling out
_ Low sex drive
_ Weight: I want __↓ or __↑
_ Crave Salt _Crave Sugar
_ Feel Cold _ Feel Hot

**Brain**
_ Poor memory
_ Fuzzy thinking/mental fog
_ I notice. _Others notice.

**Thyroid Condition**
_ Hyper _ Hypo
_ Hashimoto's

**Diabetic**
_Type 1 _Type 2 _ Pre
_ Sweaty palms, feet
_ Sweat a lot _ Don't sweat
_ Hungry __never __always
_ Thirsty __never _always

**Emotional/Spiritual**
_ Depression _postpartum
_ Low Self Esteem
_ Moody. _ PMS
_ Anxiety / Panic Attacks

**Respiratory System**
_ Shortness of Breath
_ Asthma _Allergies
_ Colds _Sinus infections
_ 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
_ Osteo _ Arthritis _ R.Arth
_ 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 _ Fungal
_ Warts/Moles _ Acne

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

**Men Only**
_ Prostate concerns _cancer
_ Jock Itch
_ Libido ↓
_ Erectile Dysfunction

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

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

**Check the food you eat:**

__ Animal: beef, chicken, turkey, etc.

__ Fish __ Eggs

__ Vegetables: __steamed __raw

__ Coffee __Tea __Water

__ Dairy: cheese, milk, yogurt, etc.

__ Fermented: sauerkraut, kefir, etc.

__ Fruit __ Juice __Kombucha

__ Wheat /Grain __ Gluten Free

__ Salt __ Sugar __ Soy

__ Honey/Maple Syrup/Agave

__ Artificial Sweeteners

__ Nuts __ Seeds

__ Alcohol: __ x per wk. __ Pop

**I am a __ Vegetarian __ Vegan.**

**I live to eat. __ I eat to live. __**