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.

My photos may be used anonymously for educational purposes.

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 _____ Email _____

Phone: _____ Date of Birth_____ Age _____

Occupation _____ Height _____ Weight _____

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." __

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."

BLOOD TYPE _____ **How many 'shots' have you had since March 2020? ___**

Continue to other side ➔

CURRENT SYMPTOMS & CONCERNS

Digestive System/GI
__Gas, __ Bloating
_ Constipation
_ Loose stool, _ Diarrhea
_ Crohn's, __Celiac, __IBS
_ Hemorrhoids, _ Bleeding
_ Oily stools, __ Smelly
_ Stomach pain, _ Ulcers
_ Nausea, _ Burping
_ Acid Reflux/Heartburn
_ Parasites

Bowels
Movements per day _____x
Color: _____
Form: _____

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

Vascular System
_ Heart Pain, __Throbs
_ Heart Pounds, _Palpitations
_ Skips a beat
_ Dizzy/Shaky, __ Tremors
_ Blood pressure: _↑ _↓
_ Cholesterol: _↑ _↓
_ Bruise easily, _Varicose v 's
_ Heart attack, _ Stroke

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

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, __postnasal 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.A.
_ Headaches __ x/ mth.
_ Head/brain injury _____x

Immune System
_ CANCER current or past
Type: _____
_ Chemo__ Radiation__
_ HIV/Hepatitis
_ Cold sores _ Genital Herpes
_ Fungus: _____
_ 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 ___ HRT__yrs.
_ Vaginal Dryness
_ C-section ___x

Men Only
_ Prostate issues
_ Jock Itch
_ Libido ↓ _ Erectile (ED)

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

Sleep
_ Troubled, wake up ___ x
_ Dream disturbed
_ Snore
_ Night sweats
_ Not refreshed
_ Sleep Apnea Machine__ yrs

Check the food you eat:

__ Beef, chicken, turkey, lamb, etc.
__ Fish __ Eggs
__ Vegetables, __ Fruit
__ Coffee, __Tea, __Juice
__ Dairy: cheese, milk, yogurt, etc.
__ Ferments: sauerkraut, kefir, etc.
__ 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.

Organic food choices = _____ %