Main Street Naturopathic Clinic

Dr. Lynn Chiasson ND 616 Main Street N. Moose Jaw, SK S6H 3K4 306-692-6160 mainnatclinic@gmail.com

HEALTH HISTORY SUMMARY

Date:_____ Appointment Date:_____

Name: _____ Age: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email address: _____ Blood Type (if known) _____

Birthdate (mm/dd/yy): _____ Place of Birth _____

Occupation: _____ Full time ☐ or Part time ☐

Employer:_____

Extended Health Care Carrier (if any) _____

Current Physician: _____

Last physician or health practitioner seen? _____ When? _____

When was your last blood test? _____ What kind? _____

How did you find out about the naturopathic services at this clinic? _____

Emergency Contact: _____

Relationship to you: _____ Contact's Phone: _____

INFORMED CONSENT FOR TREATMENT for Dr. Lynn Chiasson ND

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

If you refuse any specific procedure this will not affect your receiving other care or future treatments.

I voluntarily request Dr. Chiasson as my Naturopathic Doctor to examine and treat me and my health conditions. I understand that the course of care therapy may include the use of multiple modalities of Naturopathic Medicine including nutritional supplements, injection therapies, intravenous nutrients, homeopathic supplements, acupuncture, bowen and other therapies offered by Dr. Chiasson. I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and opportunity to ask questions about my condition, discuss naturopathic and conventional options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that payment is due in full at the time of service

I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.

All information given now or at any point in the future is confidential. It is a policy to require a medical release form before releasing records to anyone other than the patient. I certify that I have read this form or have had it read to me and that I understand its content and meaning. I have sufficient information to give this informed consent.

_____ _____ _____

Patient Name Patient Signature Date

** Please allow 2 hours for your first appointment.

Current Health Concerns

What is the main reason for coming today? If you have a specific health condition, please describe it in detail. When was the first time you noticed your condition, and describe carefully any factors that you suspect may have played a role in its onset and continuation?

List in order of importance other health concerns:

1._____ & length of time _____
2._____ & length of time _____
3._____ & length of time _____
4._____ & length of time _____
5._____ & length of time _____
6._____ & length of time _____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health care practitioner for your current problem or any other problem? _____

What was the therapy and what were the results? _____
_____

Please list the most significant, stressful events in your life. Are any of these situations continuing to impact your life:

Yes ☐ No☐ _____

_____
_____
_____
_____
_____

Which of the following have you had?

_____Pneumonia _____Tonsillitis _____Ear Infections _____Chronic infections _____ Allergies
_____Canker Sores _____Thyroid Problems _____Diabetes _____Asthma _____Eczema _____
_____Heart Disease _____Herpes _____Hepatitis _____Weight Problems _____Venereal Disease
_____Gonorrhea _____Syphilis _____Epilepsy _____High Blood Pressure _____Mononucleosis
_____Anemia

Please check off any childhood illnesses you have had:

Measles _____ mumps _____ chickenpox _____ whooping cough _____ tuberculois _____ scarlet fever _____
Polio _____ diphtheria _____ small pox _____ rheumatic fever _____ typhoid fever _____ mono _____

List of all known allergies to any drugs, herbs, foods, animals or other: _____
_____
_____

Medications

Full Name of Medication	Dosage	How long have you been taking it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries and Hospitalizations

Condition	Date
_____	_____
_____	_____
_____	_____
_____	_____

Please list any relevant family health history: _____
_____
_____
_____
_____

Your Health History

The general state of your health is: Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor ☐

On the average, describe your energy level from 1-10 (10 being the highest & 1 the lowest) _____
When during the day is your energy the best? _____ and worst? _____
Current approximate height _____ Weight _____ Weight 1 year ago _____
As an adult what has been your maximum weight? _____ minimum weight _____

Patient Intake Questionnaire

Please answer the following questions to the best of your ability. It is important that if you do not know the answer, or do not understand the question, then please leave the answer blank.

Name:_____(Please print)

Date of Birth: month_____ day_____ year_____

Place of Birth: _____

1. Are you pregnant _____
2. Do you have a pacemaker _____
3. Number of organs removed (remember tonsils & appendix) _____
4. Number of different pharmaceuticals used currently _____
5. Amount of cigarettes you smoke per day on average (or cigars) _____
6. Have you used any prednisone, cortisone, steroid creams or any steroid inhalers in the past year? (ie Pulmacort, Nasonex, etc.) If yes, how many times or frequency _____
7. Number of metal amalgam fillings in your teeth, if known _____
8. Number of street drugs used per month _____
9. Number of all known allergies _____
10. Personal stress you are under (0-10, 10 being high stress) _____
11. Number of items eaten per day whose major ingredient is white flour or sugar (include bread, soft drinks, ice cream, desserts, etc.) _____
12. Number of exercise sessions per week 20 min or more that would produce a sweat (not work-related) _____
13. Number of alcoholic drinks per day on average _____
14. Number of cups of coffee, tea per day or any caffeine product including cola's or diet cola's _____
15. Number of extreme toxic exposures in the past year (radiation, insecticides, chemicals, chemo treatments) _____
16. Number of major traumatic events in your lifetime (emotional & physical) e.g. marriage breakup, death of a loved one, major broken bone, major surgery _____
17. Number of major infections past & present (ones that hospitalized you, or serious pneumonia or bronchitis) _____
18. Number of glasses of water you drink per day on average _____
19. If you had a magic wand, how much weight would you take off? _____
20. Amount of negativity in your personality (1-10, 10 most negative) _____

Health History Summary

These forms must be completed before arriving, and brought to the appointment. Please arrive 15 minutes early so the receptionist can process your paperwork without sacrificing allotted appointment time.

Appointment Cancellation Policy

We request that 48 hours notice be given when canceling an appointment. This excludes cancellations due to poor road or weather conditions, or in the event of a sudden family crisis.

Disclaimer

While aiding in overall patient assessment, bioresonance scans do not diagnose, treat, cure or prevent any disease.

We Share The Air

Due to environmental sensitivities, please refrain from wearing colognes or perfumes.

Directions to 616 Main St. N. in Moose Jaw *Free parking in back of the clinic*

Coming from the East: Take the first exit into Moose Jaw which is Manitoba St. The first exit to your right is Athabasca St./City Centre. Follow Athabasca St. just past Main St. Turn right into the first back alley after Main St. You can angle park along the first fence to your right and come in the back door of the clinic.

Coming from the West or North: Take the Main St. exit (or if you're coming in on #2 Highway, you're already on Main St.). Follow Main St. past 5 sets of traffic lights. Turn right at the next set of lights which is Athabasca St. Turn right into the first back alley. You can angle park along the first fence to your right and come in the back door of the clinic.

Coming from the South: You will come in on 2nd Ave. S.E. Follow 2nd Ave. to Manitoba St. Turn left on Manitoba St. to Main St. Turn right. Take Main St. to Athabasca St. Turn left. Turn right into the first back alley. You can angle park along the first fence to your right and come in the back door of the clinic.

Discount Policies

$$ Buy 5 of the same product and get 1 at no charge if purchased at the same time
$$ 5% discount on cash product purchases
$$ Buy 2 of the same product and get 10% off those products
We accept Visa, Mastercard, Debit, Cheques and Cash

Re-Ordering Products

We would be happy to mail supplements to you. Please call our clinic 10 days before you run out of your products. We can take payment over the phone and have the products to you within days if the product is in stock.

Name:		Weekly Diet Diary			Date:	
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
a.m	a.m.	a.m.	a.m.	a.m.	a.m.	a.m.
Noon	Noon	Noon	Noon	Noon	Noon	Noon
p.m.	p.m.	p.m.	p.m.	p.m.	p.m.	p.m.
Comments, feelings, overview of the day. How do you feel? What is your energy level? Digestive issues? Etc.:						
**Include: What and how much was eaten, condiments, drinks (tea, coffee, soda, water, alcohol etc.) snacks, etc.						