Main Family Chiropractic &
Functional Medicine Centre
Dr. Jennifer Tremain

200 King St E Suite 205
905-697-8083/ fax 905-697-8084
info@mainfamilychiro.com/ www.mainfamilychiro.com

Dear Patient,

Welcome! And thank you for choosing Dr. Jennifer Tremain as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:

During your initial consultation Dr. Jenn will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2:

Once you have completed your lab tests, Dr. Jenn will explain the meaning of your test results to you in a follow up consultation. She will create an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

STEP 3:

Subsequent consults are scheduled every 4-6 weeks to monitor your progress

We invite you to contact us via email or phone should you have any questions during the course of your treatment. We may be reached at 905-697-8083 or info@mainfamilychiro.com

We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

Yours in Health, Naturally

Dr. Jennifer Tremain and Staff

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I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Dr. Jennifer Tremain to release my personal medical information to me.

Patient's Signature: _____ Date: _____

Name:				Date:
Address:				Country:
City:		Prov:		Postal Code:
Home Phone:	Work Phone:			Fax:
E-mail:				Cell Phone:
Please mark your preference for occasional follow up communication from our office: _____Email _____Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	# of Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:				Referred by:
What is your major complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

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Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ **Height** _____ **Blood Pressure** (if known) _____ **% Body Fat** (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____
please list (attach sheet if necessary)

_____

2. In the past, have you used birth control pills and/or antibiotics?_____

a. For how long?_____

3. If you have fillings, please list material(s) used:_____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

***Pre & Peri Menopausal Women**

Frequent/irregular periods	□ Yes □ No	Moody or irritable during or before periods	□ Yes □ No
Severe abdominal cramping w/periods	□ Yes □ No	Trouble sleeping due to racing mind/thoughts	□ Yes □ No
Breast tenderness around periods	□ Yes □ No	Trouble getting pregnant/miscarriage(s)	□ Yes □ No
History or current uterine fibroids	□ Yes □ No	Anxiety of panic attacks	□ Yes □ No
Depression or post-partum depression	□ Yes □ No	Current/past use (2yrs) of birth control pills	□ Yes □ No
Headaches/migraines at time or period	□ Yes □ No	History of no period for 3 months at a time	□ Yes □ No
Cravings for sugar, fat, salt or chocolate	□ Yes □ No	Bloating/water retention with periods	□ Yes □ No
Pain during intercourse	□ Yes □ No	Family history or breast/uterine/ovarian cancer	□ Yes □ No
Endometriosis	□ Yes □ No		

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***Post Menopausal Women**

Hot flashes	□ Yes □ No	Your last menstrual period was > 1 yr ago	□ Yes □ No
Severe sweating at night	□ Yes □ No	Concern for osteoporosis or hip/spinal fracture	□ Yes □ No
Vaginal dryness	□ Yes □ No	Trouble sleeping due to mind racing/thoughts	□ Yes □ No
Vaginal thinning	□ Yes □ No	Get anxiety or panic attacks	□ Yes □ No
Reduced libido	□ Yes □ No	Family history of breast/uterine/ovarian cancer	□ Yes □ No
Pain during intercourse	□ Yes □ No	Take hormone replacement (pills, cream)	□ Yes □ No
History of hysterectomy	□ Yes □ No		

5. How much sleep do you get each night on average?_____

6. Do you have any food allergies, sensitivities or restrictions?_____

_____

7. Do you smoke, drink alcohol or use recreational drugs?_____

a. How much, how often?_____

b. How often do you drink caffeinated beverages?_____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):_____

_____

9. Are there foods that you eat on a daily basis, almost daily basis?_____

_____

a. Do you "miss" these foods if you do not eat them?_____

10. Write briefly about your weight gain/loss history:_____

_____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

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11. Please list close relatives that have diabetes, heart disease or obesity:_____

_____

12. What methods have you tried to lose/gain weight_____

_____

13. How is your energy level?_____

a. Are there times in the day that you feel best?_____worst?_____

14. Are you happy in your life right now?_____

a. When as the last time you felt healthy and happy?_____

15. What are your main sources of stress_____

_____

16. How do you deal with your stress?_____

_____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes_____ No_____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes_____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes_____ No_____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes_____ No _____

e. Now and then I think I am a secret eater. Yes _____ No_____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes_____ No_____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes_____ No_____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No_____

i. I feel shaky if I don't eat on time or if I don't snack. Yes_____ No_____

j. I often find myself irritable or angry. Yes_____ No_____

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18. Check off any of the following that have applied to you within the last 30 days:

_____Do you feel nauseous?	_____Do you have abdominal/intestinal pain?
_____Do you have bloating?	_____Do you get bloated after meals?
_____Do you get heartburn?	_____Do you have diarrhea?
_____Do you have constipation?	_____Do you travel outside of the Canada/USA?
_____Do you have gas?	_____Are your stools compact/hard to pass?
_____Do you belch following meals?	_____Do you have gurgles in your stomach?
_____Do your bowel movements alternate between constipation and diarrhea?	

19. In your estimation, how physically fit are you right now?

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

20. How often do you exercise? _____

a. What is your regimen?_____

_____

_____

21. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? _____

_____

22. What are your fitness goals? (circle all that apply)

_____ General fitness endurance_____	Muscle toning
_____ Weight loss/maintain weight	_____ Muscle strengthening
_____ Osteoporosis prevention	_____ Muscular coordination/balance
_____ Specific sport enhancement _____	Other_____
_____ Flexibility	_____

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23. Surgeries, starting with most recent:_____

24. Hospitalizations:_____

25. Briefly describe any childhood traumas (i.e. abuse, bullied, broken bones, concussions etc.):_____

_____

_____

_____

_____

26. Describe the periods in your life when you were under a significant amount or stress?

_____

_____

_____

_____

_____

27. What is your heritage? (Irish, German, Spanish, etc.) _____

28. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	**Do you often:**
Now Past **Satisfactory**	Now Past **Feel depressed**
Now Past **Boring**	Now Past **Have anxiety**
Now Past **Demanding**	**Do you often:**
Now Past **Unsatisfactory**	Now Past **Have irrational fears**
Do you worry over:	Now Past **Feel upset**
Now Past **Home life**	Now Past **Feel things go wrong**
Now Past **Marriage**	Now Past **Feel shy**
Now Past **Children**	Now Past **Cry**
Now Past **Job**	Now Past **Feel inferior**
Now Past **Income**	**Have you:**
Now Past **Money problems**	Now Past **Seriously considered suicide**
	Now Past **Attempted suicide**

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POLICIES AND PROCEDURES

New Patients

First Appointment

Your first consultation will be 60-75 minutes $200.00. During this time Dr. Jenn will determine the appropriate lab tests you should order to address your specific health concerns.

Fee Schedule

New Patient consultation: $200.00 (60 -75 minutes)
1 hour: $100
45 minutes: $75
30 minutes: $50

- Payment is due at time of consultation
- Methods of payment are: Cash, Debit, Visa, MasterCard or Certified Cheque.
- All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments

- Follow-up consults may be scheduled in 30, 45, or 60-minute blocks of time.
- We encourage you to book your appointments 2 weeks in advance.
- As a courtesy to you, our office will send you a reminder email so you are able to confirm your appointment directly from the email.

Lab Tests

- The results of your lab test(s) will be sent to Dr. Jennifer Tremain 2 to 4 weeks after mailing your specimens to the lab.
- Dr. Jenn will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

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Cancellations

- If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Returned Products

- **PRE-APPROVAL is REQUIRED on ALL RETURNS!!**
- **Refrigerated items CANNOT be returned**
- 15% restock fee of purchase price less shipping and handling may be refunded on unopened and non-refrigerated items
- No supplement returns will be accepted after 30 days on all regularly stocked items. Special orders CANNOT be returned!
- Prepaid tests can be returned for credit within one year of purchase.

I _____ have read and understood
(*please print name*)
Main Family Chiropractic and Functional Medicine's Policies and Procedures.

Date_____

Signature_____