MAIN FAMILY CHIROPRACTIC CENTRE

Dr. Jennifer Tremain
27 Vesna Crt.
Bowmanville, ON L1C 0C7
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 to monitor your progress. Dr. Jenn **will also design an on-going wellness program to be reviewed and updated with our staff at no charge every six months.**

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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New Patient Paperwork

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	

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

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?____

15. What are your main sources of stress____

____

16. How do you deal with your stress?____

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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_____

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 Canada/U.S?
_____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?	

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

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

25. How often do you exercise? ____

a. What is your regimen?____

____

____

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

____

27. 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	

28. Surgeries, starting with most recent:____

29. Hospitalizations:____

30. Briefly describe where you have lived since childhood:____

____

____

31. What is your heritage? (Irish, German, Spanish, etc.) ____

32. 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**

POLICIES AND PROCEDURES

New Patients

First Appointment

Your first consultation will be 45 minutes – 1 hour ($110.00) During this time Dr. Jenn will determine the appropriate lab tests/supplements you should order to address your specific health concerns.

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.