



Include in the client's file

File Opening Formality

CONSULTATION PREREQUISITE

The client:

Name

Surname

Age

Address

Home Telephone

Office Telephone

Referred by

Reason for consulting

The client has an insurance plan
including « naturopathy »

☐ Yes ☐ No

Name of the insurance company

*E-mail

1. testifies that she/he has required the services of the naturopath on his own free will and that she/he has done so without having been pressured;

2. recognizes that she/he is responsible of using the medical vocabulary that she/he uses and that she/he cannot impute the responsibility on the naturopath, even if the naturopath uses these terms for explanation purposes;

3. is aware that she/he cannot ask the naturopath to perform any medical act or give a diagnostic reserved to allopathic medicine practitioners (for example prescribed pharmaceutical drugs), chiropractors and others related to the professional code, nor that she/he will incite the therapist to do so;

4. acknowledges that the naturopath, did not, at any time, suggest that the client discontinue use of his prescribed allopathic medicine;

5. has given information regarding her/his private file. Following the adoption of Bill 68, and unless otherwise instructed by yourself, we shall consider that you consent to our keeping in a file, all information you have already given or may give us, orally or in writing. We shall also consider, unless otherwise instructed by yourself by registered mail, that your consent will be valid for a period of five (5) years;

6. recognizes that the receipt issued by the therapist is emitted strictly in the intention of acknowledgement of receipt of sums paid for services rendered. The use of this receipt, for any given purpose, including, without limitation, the reimbursement of this amount by anyone, including an insurance company, remains the entire and exclusive responsibility of the client, the therapist not being involved or having any knowledge in any way about the admissibility or the non-admissibility of this receipt for any purpose.

The client acknowledges that she/he has honestly and lawfully introduced himself and for no other purpose than true health care.

The client by her/his signature, testifies to the knowledge and comprehension of the content of the above and accepts to comply to these rules.

Signed in

Date (D / M / Y)

Signature

Name of client in block letters



Health Evaluation

Personal Information

Name _____		Date of first consultation J / M / A
Surname _____		
Marital Status _____	Number of dependent children _____	Interests _____
Occupation _____	Age _____	

Measurements

Weight _____	Size _____	Frame
Eye Color _____	Hair Color _____	☐ Fine ☐ Average ☐ Large

Purpose of the consultation

Disease (s) mentioned by the client _____ _____	Date of the last meeting with doctor J / M / A
Diagnosed by ☐ Doctor ☐ Other : _____	
Name of attending doctor _____	

Triggering factors

You think your problems started after :

Heredity

Family diseases	Yes	No	Age
_____ Deceased Father	☐	☐	☐
_____ Deceased mother	☐	☐	☐
_____ Deceased brother	☐	☐	☐
_____ Deceased sister	☐	☐	☐

Drug information

Do you take any prescribed medication by your doctor? ☐ Yes	Oral contraceptives ? ☐ Yes, which ones?
If yes, please list: _____ _____ _____	☐ IUD ☐ Prostheses ☐ Orthotics Other _____



Health Evaluation

Nutrition Information

Food frequency

Only food acceptable for snaking at night : apple or orange.

☐ Breakfast → ☐ Snack → ☐ Lunch → ☐ Snack → ☐ Supper → ☐ Snack

Do you salt your food ?

☐ Little ☐ a lot

Liquid

☐ Soft drink ☐ Water ☐ Coffee ☐ Tea

How do you usually cook your food ?

☐ with fat ☐ without fat

Appetite

☐ Little ☐ a lot

☐ Alcohol Other _____

Do you often consume sugar
(pastries included) ?

☐ Yes ☐ No

Additional health information

- | | | | |
|---------------------------------------|---|--|-------------------------------------|
| ☐ Allergies | ☐ Hair loss | ☐ Influenza (common) | ☐ Phlebitis |
| ☐ Anaemia | ☐ Cancer | ☐ Pregnancy | ☐ Phobias |
| ☐ Asthma | ☐ Cystitis | ☐ High blood pressure | ☐ Pneumonia |
| ☐ Acne | ☐ Itching | ☐ Hernia | ☐ Cold |
| ☐ Angina | ☐ Depression | ☐ Hypercholesterolemia | ☐ Rheumatism |
| ☐ Arthritis | ☐ Dyspepsia | ☐ Myocardial | ☐ Sclerosis |
| ☐ Atherosclerosis | ☐ Dizzy spell | ☐ Sore throat, stomach aches | ☐ Sinusitis |
| ☐ Ringing (ears) | ☐ Eczema | ☐ Mononucleosis | ☐ Triglyceride |
| ☐ Bronchitis | ☐ Epilepsy | ☐ STD | ☐ Stomach ulcer |
| ☐ Burn out | ☐ Frigidity (powerlessness) | ☐ Obesity | ☐ Vertigo |
| ☐ Bursitis | ☐ Gastritis fever | ☐ Parkinson | ☐ Worms |
| ☐ Spinal problems | ☐ Gout | ☐ Pancreatitis | |
| ☐ Other | _____ | | |

Blood Pressure

☐ High

☐ Low



Health Evaluation

Physical evaluation - symptoms

Circulatory Functions

- | | |
|----------------------------------|--|
| ☐ Leg cramps | ☐ Cold extremities |
| ☐ Numbness | ☐ Bruising |
| ☐ Feebleness | ☐ Breathlessness |
| ☐ Varicose | ☐ Palpitations |
| ☐ Cellulitis | ☐ Hemorrhoids |

Hepatic Functions

- | | |
|---|---------------------------------------|
| ☐ Gallbladder operation | ☐ Large liver |
| ☐ Gallstones | ☐ Back points |
| ☐ Excess bile | ☐ Waves of nausea |
| ☐ Vomiting | ☐ Cirrhosis |
| ☐ Black spots (vision) | ☐ Hepatitis |

Intestinal Functions

- ☐ Constipation (Without medicine)

If so, stool frequency ____ by day

- ☐ Colitis ☐ Enteritis

- ☐ Diarrhea ☐ Pale stools ☐ Gas

Patient suffering from this problem since ?

____ month(s) ____ year(s)

Nervous system evaluation

- | | |
|-----------------------------------|----------------------------------|
| ☐ Migraines | ☐ Fatigue |
| ☐ Insomnia | ☐ Exhaustion |
| ☐ Nervousness | |
| ☐ Dreams | |
| ☐ Depression | |

Renal Fonctions

- | | |
|---|--|
| ☐ Morning fatigue | ☐ Swelling of eyes |
| ☐ Numbness | ☐ Swelling of feet |
| ☐ Hand swelling | ☐ Heariness in kidney area |
| ☐ Dark circles under eyes | ☐ Frequent urinating |
| ☐ Burning bladder | ☐ Blood in urine |

Stomach Functions

- | | | | |
|--------------------------------------|---------------------------------|--|----------------------------------|
| ☐ Slow digestion | ☐ Bloating | ☐ Stomach cramps | ☐ Bad breath |
| ☐ Stomach gas | ☐ Heartburn | ☐ Suffering vomiting | ☐ Ulcer |

Ovarian Functions

- | | |
|---|---|
| ☐ Irregular menstruation | ☐ Vaginal infection |
| ☐ Absence of menstruation | ☐ Menopause |

Thyroid Functions

Has your doctor diagnosed a thyroid malfunction ?

☐ Yes ☐ No

In general, how long have you suffered from these symptoms ? ____ month(s) ____ year(s)



Mutual Agreement

Rescheduled or cancelled appointment

The implementation of the requested service starts several days in advance and an ongoing preparation is necessary and must be done for the type of service you book. This service also includes a physical or virtual meeting moment, the “appointment”. The service that is requested and booked therefore begins well before the scheduled date and time of the actual appointment. This is why a cancellation and rescheduling policy is necessary and thus provided for, since the service is not fractionable and becomes due in full as soon as it begins to be provided, i.e. more than 72 hours before the scheduled meeting time.

Therefore, out of respect for the mutual commitment to honor the time of the appointment as well as the service requested and provided, in the event that an appointment must be postponed or cancelled, **it is necessary to advise by phone at (514) 990-2699 (no texting, it is a landline) at least 72 business hours before the scheduled time and date.** (Sunday is a holiday, so add 24 additional hours for Monday appointments)

If the minimum 72 hours delay is not respected, the customer agrees to pay in full the cost of the service requested and received, within 48 hours of the time and date of the cancelled or rescheduled appointment. If this delay is not respected, administrative fees may apply in addition.

If you are unable to attend the office appointment or cancel within the specified time frame, for any reason, including Covid, your appointment will be held via tele-consultation, either by phone, Skype or Messenger, Zoom, etc., as available.

Being late for an appointment

If there is a delay of more than 10 minutes without having warned the consultant **by phone at 514-990-2699 (No text messages. It's a land line)**, it is the consultant's discretion to wait for the client or to leave the office after 20 minutes of being late. The costs of the appointment will also be charged in full if applicable.

I have read, I understand, and I agree to these terms and conditions:

Client's signature
(Enter your full name if filled out by computer)



Pascal N. Paquette

N.B. Terms and conditions are subject to change without notice, as are the costs related to the various services, trainings and workshops. The latest version posted on this website is the one to which a client agrees by default, either by requesting a service or by registering for a workshop or training.