

**Rassel-Daigneault Holistic Health Center**  
**NEW PATIENT INFORMATION FORM**

Please print clearly:

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Apt.# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
E-mail Address \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex: M/F Height \_\_\_\_\_ Weight \_\_\_\_\_

Overall health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint \_\_\_\_\_

Other complaints or problems: (use separate sheet if needed) \_\_\_\_\_

Current medications/drugs being taken: (use separate sheet if needed) \_\_\_\_\_

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Nutritional supplements being taken: \_\_\_\_\_

Do you smoke, chew tobacco, use marijuana, CBD, drink coffee or alcohol? (if yes indicate how much) Cigarettes/Vape \_\_\_\_\_ Coffee \_\_\_\_\_

Alcohol \_\_\_\_\_ Marijuana \_\_\_\_\_ CBD \_\_\_\_\_

**HISTORY:**

List any major illnesses (with approx. dates): \_\_\_\_\_

List any surgery or operations with approx. date: \_\_\_\_\_

Past Accidents or injuries: \_\_\_\_\_

Marital Status: S M D W Name of Spouse \_\_\_\_\_

Describe health of spouse: Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Number of children if any \_\_\_\_\_

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other \_\_\_\_\_

Any household pets or other animals you or family members are in close contact with:  
\_\_\_\_\_

**PLEASE READ BEFORE SIGNING:**

I specifically authorize Dr. Jean-Guy Daigneault and/or Helena Miller to perform a nutrition testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **nutrition testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that nutrition testing is not a method for "diagnosing" or "treating" any disease including conditions of cancer, HIV, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of nutrition testing or any natural health, nutritional or dietary programs recommended, but rather I understand that nutrition testing is a means by which the body's natural reflexes can be used as an aid in determining possible nutritional imbalances so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understood the foregoing. This permission form applies to subsequent visits and consultations

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_