

The Healing Joint

Jeanette Musset, NMD

Patient Information Form

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Date of Birth (*required*): ____ / ____ / ____ Gender: _____

Address: _____ Unit #: _____

City: _____ State: _____ ZIP: _____ Email: _____

Phone *Appointment reminders will be send to 1st preference*

1. Home Work Cell (_____) _____ 2. Home Work Cell (_____) _____

***Confidential voicemails OK?** Yes No ***Confidential voicemails OK?** Yes No

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Are you currently employed? No Yes Employee/Address:

Patient Profile

Reason for Visit, please explain: _____

IMPORTANT: Do you have any **medication allergies or any allergic reactions** to anything else? Yes No

If **YES** please explain: _____

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if needed.

Name of medication

Strength

Directions

*(such as Synthroid, Vitamin D,
etc.)*

(88mcg, etc.)

*(such as 1 tablet twice a day, as needed,
etc.)*

Check if none

Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition, if applicable such as mother (M), father (F), sibling (S) or maternal or paternal grandmother/grandfather (MGM, MGF, PGM, or PGF).

Condition	SELF	RELATIVE	Condition	SELF	RELATIVE
Allergies			HIV/AIDS		
Anemia			Hypertension		
Anxiety			Irritable Bowel Syndrome		
Arthritis			Kidney Disease		
Asthma			Meningitis		
Blood Transfusion			Nerve/Muscle Disease		
Cancer			Osteoporosis		
Cataracts			Parkinson's/Alzheimer's		
Congestive Heart Failure			Seizures		
Clotting Disorder			Sickle Cell Anemia		
COPD			Stroke		
Depression			Substance Abuse		
Diabetes			Thyroid Disease		
Emphysema			Tuberculosis		
GERD			Ulcers		
Glaucoma			Other		
Heart Attack			Other		
Heart Murmur			Other		

Please list any surgeries or hospital stays you have had and their approximate date/year:

Social History

Do you use any of the following substances regularly?

<input type="checkbox"/> Coffee/Black Tea/Cola	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Recreational Drugs	<input type="checkbox"/> Tobacco- Current /Past / Never
Current or Past Tobacco Use:	Packs Per Day: _____	How Long: _____	Quit: _____
Please mark those that apply: <input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Significant Other	Other: _____
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what are their ages: _____		

Do you follow any particular diet restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please describe: _____ _____
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Do you exercise regularly? Yes No
If YES, please describe type of exercise and how often.

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Jeanette Musset, NMD, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, and laboratory, x-ray.

Minor office Procedures: e.g., dressing a wound, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections. **Botanical Medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.

Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Pharmaceuticals: e.g., antibiotics, hormones, and other pharmaceutical medications & **Other Naturopathic Modalities**

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from infections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Payment Policy: Payment is due at the time of service. Cancellations must be made at least 24 hours in advance or patient will be billed for full amount of appointment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Jeanette Musset, NMD, or any of her personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my practitioner will answer any questions I have to the best of her ability.

Notice of Privacy Practices -- Acknowledgment

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I may also ask to correct that record. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research or educational purposes, and that my identity will be protected and kept confidential. (Our **Notice of Privacy Practices** is available to you and describes in more detail how your health information may be used and disclosed, and how you can access your information.) By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Date

Signature of Patient/ Parent or Guardian