

## Pediatric Intake Form

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY) Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Name of Parent's/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message? Yes/No

Parent's Work Phone: \_\_\_\_\_ May we leave a message? Yes/No

Parent's Email: \_\_\_\_\_

May we add you to our seasonal newsletter and calendar of events via email? Yes/No  
(Your email will not be shared)

Height (of child): \_\_\_\_\_ Weight (of child): \_\_\_\_\_

Are there any siblings? \_\_\_\_\_ Age (s): \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Who can we thank for your referral? \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

### Family Doctor

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last appt. /physical: \_\_\_\_\_

### Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last appt. /physical: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last appt. / physical: \_\_\_\_\_

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Is your child currently taking any medication? Yes  No

If yes, please specify: \_\_\_\_\_

Has your child taken any medications for an extended period of time in the past? Yes  No

If yes, please specify: \_\_\_\_\_

Is your child taking any herbal or vitamin supplements? Yes  No

If yes, please specify: \_\_\_\_\_

Has your child received vaccinations? Yes  No

Does your child receive exercise? Yes  No

What complaint/concern brings you in? \_\_\_\_\_

How long has your child been experiencing this? \_\_\_\_\_

Is it getting better, worse, or staying the same? \_\_\_\_\_

Have you seen other health professionals regarding this complaint? Yes  No

If yes, whom? \_\_\_\_\_

What treatment did they use? \_\_\_\_\_

Has your child taken any medication for this complaint? Yes  No

Has your child ever experienced this complaint before? Yes  No

Did they receive any treatment at this time? Yes  No

Has your child had x-rays in relation to the current complaint? Yes  No

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### Child Health History

Please CHECK anything which is currently causing your child problems/concerns.

Please CIRCLE anything which has been a problem/concern for your child in the past.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ear Infections               | <input type="checkbox"/> Scoliosis        | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Chronic Colds                | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Upper Respiratory Infections | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Food Sensitivities     |
| <input type="checkbox"/> Digestive Problems           | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Sinus Troubles               | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Bed Wetting            |
| <input type="checkbox"/> Colic                        | <input type="checkbox"/> Growing Pains    | <input type="checkbox"/> Eczema/Skin Irritation |
| <input type="checkbox"/> Neck Pains                   | <input type="checkbox"/> Back Pains       | <input type="checkbox"/> ADD/ADHD               |

Has your child experienced any of the following illnesses:

- |                                      |   |                                |
|--------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Rubella     | <input type="checkbox"/> Rubeola        |                                |
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**Developmental History**

- Has your child ever fallen from any high places? Yes  No
- Is/was your child ever involved in contact sports? Yes  No
- Has your child ever been involved in a motor vehicle accident? Yes  No
- Has your child ever been seen on an emergency basis? Yes  No
- Has your child ever broken any bones? Yes  No
- Has your child had any previous hospitalizations? Yes  No
- Has your child had any previous surgeries? Yes  No

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**Prenatal History**

- Ultra-sounds during pregnancy: Yes  No
- Medications during pregnancy: Yes  No  If yes, please specify: \_\_\_\_\_
- Medications during labour/delivery: Yes  No  If yes, please specify: \_\_\_\_\_
- Were you induced? Yes  No
- Was your child at anytime during pregnancy in an intra-uterine constricting position, such as:  
Breech  Transverse  Face/Brow presentation
- Was your delivery vaginal or C-section? \_\_\_\_\_
- If it was a C-section was it planned or emergency? \_\_\_\_\_
- Were any of the following used during the delivery:  
Forceps  Vacuum Extraction  Other, please specify: \_\_\_\_\_
- Were there any complications during delivery? Yes  No  if yes, please specify: \_\_\_\_\_
- Was your child breastfed? Yes  No  If yes, for how long? \_\_\_\_\_

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What do you hope to achieve for your child by coming to Village Wellness?

\_\_\_\_\_

Our primary goal is to work towards the resolution of your current condition as quickly as possible through excellent health care and patient education while helping to prevent you from experiencing this condition again.

Do you have any specific concerns about the therapies that we provide?

\_\_\_\_\_

We will always give a thorough explanation of what we've found in our history and physical exam; explain the condition we believe you to be suffering from as well as the treatment options available to you, the expected outcome and any risks involved. Always feel free to ask questions at any stage of your treatment, good communication is an important part of the treatment and prevention process at Village Wellness.

I hereby authorize the healthcare professionals at Village Wellness, with my prior knowledge, to release to or obtain any health information from other health care providers as may be required for the management of my case.

I have read and understood the Village Wellness at Appaloosa fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Village Wellness Fee Schedule and Cancellation Policy

### Chiropractic Services

Initial Chiropractic Exam/Acupuncture/Laser Therapy	\$90
Subsequent Chiropractic	\$50
Subsequent Laser (30 minute treatment)	\$50
Subsequent Acupuncture	\$60
Combination Chiropractic and Laser	\$65
Combination Chiropractic and Acupuncture	\$90

### Children, Students, Seniors

Initial Chiropractic Exam/Acupuncture/Laser Therapy	\$80
Subsequent Chiropractic	\$45
Subsequent Laser (30 minute treatment)	\$45
Subsequent Acupuncture	\$55
Combination Chiropractic and Laser	\$60
Combination Chiropractic and Acupuncture	\$80

### Orthotics

Custom Orthotic Inserts	\$320
Custom Orthotic Shoes	\$420

### Dietician

Initial Nutrition Consultation	\$80
Follow-up Appointment	\$40

### Massage Therapy

30 Minute Massage	\$48 + tax = \$55.20
45 Minute Massage	\$63 + tax = \$72.45
60 Minute Massage	\$78 + tax = \$89.70
90 Minute Massage	\$125 + tax = \$143.75
60 Minute Hot Stone Massage	\$85 + tax = \$97.75
90 Minute Hot Stone Massage	\$130 + tax = \$149.50

### Reflexology

60 Minute Reflexology	\$78 + tax = \$89.70
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### Hours of Operation

#### Chiropractic/Acupuncture/Laser Therapy

Monday 8am- 8pm
Tuesday 10am- 6pm
Wednesday 12pm- 8pm
Thursday 10am- 6pm
Friday 8am-1pm

#### Massage Therapy

Monday 11am- 8pm
Tuesday 10am- 6pm
Wednesday 12 pm- 8pm
Thursday 10am- 6pm
Friday 8am- 1pm

- ✓ We ask that you provide a **MINIMUM 24 HOURS** notice cancellation or risk being charged a **\$25 fee for the missed appointment**
- ✓ If you are calling outside business hours then please leave a message and we will be happy to re-schedule your appointment
- ✓ There will be a \$25 per page charge for medical letters written for referrals for massage therapy or orthotics if requested by your insurance company
- ✓ Initial Exam fee includes chiropractic treatment/acupuncture treatment/laser therapy treatment
- ✓ All payments for services are due at the time of the scheduled appointment
- ✓ Receipts will be issued for reimbursement by your insurance company
- ✓ Those clients with Blue Cross (Veterans, National Defence, and RCMP, also included) or Greenshield are eligible for direct billing. If your coverage does not cover 100% of billings you will be responsible for the remaining balance at the time of each visit
- ✓ Children are considered those from infancy to age 17, Students must show valid ID and seniors are those age 65+

I have read, understood and agreed to the above terms and policies

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_