

## Patient Intake Form

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

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

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

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

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

Work Phone: \_\_\_\_\_ May we leave a message for you? Yes/No

Cell Phone: \_\_\_\_\_ May we leave a message for you? Yes/No

Email: \_\_\_\_\_

May we add you to our seasonal newsletter and calendar of events via email? Yes/No

(Your email will not be shared)

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

Occupation: \_\_\_\_\_ Do you primarily sit or stand at work? \_\_\_\_\_

Do you use a computer for long periods at work? Yes/No

What is your current Height? \_\_\_\_\_ Weight? \_\_\_\_\_

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### Emergency Contact

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

Relationship to you: \_\_\_\_\_

### Family Doctor

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

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

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

### Other Health Care Professionals

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

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

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

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

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

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

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

Do you currently take any **prescription medication**? Yes/No

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

Do you currently take any **over the counter medication**? Yes/No

If yes, please specify which: \_\_\_\_\_ For what complaint: \_\_\_\_\_

How often do you take this medication? \_\_\_\_\_

Do you currently take any vitamins or natural supplements? Yes/No

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

Please list any prescription drugs, over the counter medications or supplements that you have taken in the past:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you do weight bearing exercises? Yes/No If yes, how often? \_\_\_\_\_

Do you do cardiovascular exercises? Yes/No If yes, how often? \_\_\_\_\_

Do you smoke? Yes/No If yes, how many per day or week? \_\_\_\_\_

Do you drink alcohol? Yes/No If yes, how many drinks per week? \_\_\_\_\_

Do you use any recreational drugs? Yes/No If yes, how often? \_\_\_\_\_

Have you had any prior surgeries? Yes/No \_\_\_\_\_

Have you had any prior hospitalizations? Yes/No \_\_\_\_\_

Have you had any broken bones? Yes/No \_\_\_\_\_

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### **Females Only**

Are you currently pregnant? Yes/No

Number of pregnancies? \_\_\_\_\_ Number of children? \_\_\_\_\_

Have you ever taken any pharmaceutical forms of birth control? Yes/No

Are you currently taking any pharmaceutical forms of birth control? Yes/No

### **Males Only**

Have you ever had your prostate examined by a medical doctor? Yes/No

Do you have regular prostate exams? Yes/No

### Patient Health History

Please **CHECK** anything which is currently causing you problems/concern.

Please **CIRCLE** anything which has been a problem/concern in the past.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Tingling                | <input type="checkbox"/> Headache                  | <input type="checkbox"/> Low Blood Pressure     |
| <input type="checkbox"/> Weakness                | <input type="checkbox"/> Migraine                  | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Numbness                | <input type="checkbox"/> Fever                     | <input type="checkbox"/> High Cholesterol       |
| <input type="checkbox"/> Loss of strength        | <input type="checkbox"/> Sweats                    | <input type="checkbox"/> Heart or Blood Disease |
| <input type="checkbox"/> Swollen Joints          | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> TMJ Pain R/L            | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Neck Pain R/L           | <input type="checkbox"/> Loss of Sleep             | <input type="checkbox"/> AIDS/HIV               |
| <input type="checkbox"/> Shoulder Pain R/L       | <input type="checkbox"/> Weight Loss               | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Elbow Pain R/L          | <input type="checkbox"/> Chronic Cough             | <input type="checkbox"/> Hemophilia             |
| <input type="checkbox"/> Wrist Pain R/L          | <input type="checkbox"/> Spitting up Blood         | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Hand Pain R/L           | <input type="checkbox"/> Blurred Vision            | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Mid Back Pain R/L       | <input type="checkbox"/> Difficulty Breathing      | <input type="checkbox"/> Phlebitis              |
| <input type="checkbox"/> Low Back Pain R/L       | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Hip Pain R/L            | <input type="checkbox"/> Deafness                  | <input type="checkbox"/> Fibromyalgia           |
| <input type="checkbox"/> Knee Pain R/L           | <input type="checkbox"/> Ringing in the Ears       | <input type="checkbox"/> Nausea                 |
| <input type="checkbox"/> Ankle Pain R/L          | <input type="checkbox"/> Double Vision             | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Foot Pain R/L           | <input type="checkbox"/> Sinus Problems            | <input type="checkbox"/> Bed Wetting            |
| <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Earache                   | <input type="checkbox"/> Blood in the Urine     |
| <input type="checkbox"/> Rashes                  | <input type="checkbox"/> Frequent Colds            | <input type="checkbox"/> Indigestion            |
| <input type="checkbox"/> Dry Skin                | <input type="checkbox"/> Difficulty Swallowing     | <input type="checkbox"/> Vomiting               |
| <input type="checkbox"/> Infectious Skin Disease | <input type="checkbox"/> Enlarged Lymph Glands     | <input type="checkbox"/> Frequent Urination     |
| <input type="checkbox"/> Varicose Veins          | <input type="checkbox"/> Speech Problems           | <input type="checkbox"/> Kidney Infection       |
| <input type="checkbox"/> Itchy Skin              | <input type="checkbox"/> Persistent Fatigue        | <input type="checkbox"/> Gallbladder Problems   |
| <input type="checkbox"/> Hives                   | <input type="checkbox"/> Swelling of Ankles        | <input type="checkbox"/> Difficulty Urinating   |
| <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Ulcers                    | <input type="checkbox"/> Kidney Stones          |
| <input type="checkbox"/> Eczema/Psoriasis        | <input type="checkbox"/> Bleeding Disorder         | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Belching or Gas         | <input type="checkbox"/> Easily Bruise             | <input type="checkbox"/> Breast Lump/Pain       |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Heat and Cold Intolerance |   |

### Women Only

- |  |   |
|--|---|
| <input type="checkbox"/> Severe Menstrual Cramps | <input type="checkbox"/> Loss of Menstruation |
| <input type="checkbox"/> Hot Flashes             | <input type="checkbox"/> Irregular Cycles     |

### Family History

Have your grandparents, parents, siblings or children ever been diagnosed with any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure                      | <input type="checkbox"/> Thyroid Problems                            | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> High Cholesterol                         | <input type="checkbox"/> Hormone Problems                            | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Diabetes<br>(type I or type II)          | <input type="checkbox"/> Breathing or Lung Problems<br>(e.g. asthma) | <input type="checkbox"/> Neurological Conditions<br>(e.g. ALS, MS, Parkinson's, CP, TBI) |
| <input type="checkbox"/> Stroke                                   | <input type="checkbox"/> Rheumatoid Arthritis                        | <input type="checkbox"/> Mental Illness  |
| <input type="checkbox"/> Heart Disease                            | <input type="checkbox"/> Osteoarthritis                              | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> I do not know my family medical history. | <input type="checkbox"/> Other _____                                 |  |

What would you like to achieve by coming to Village Wellness?

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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 we provide?

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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 health care professionals at Village Wellness, with my prior knowledge, to release or to obtain any health information from my 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 I am responsible for any outstanding balance not covered by my insurance policy.

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

## Pregnancy Chiropractic and Massage Patient Intake Form

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**Primary Complaint:**

What is your current concern? \_\_\_\_\_

Where do you feel the discomfort? \_\_\_\_\_

How would you describe the pain? \_\_\_\_\_  
(stabbing, dull, achy, stiff & tight, burning, pins and needles, etc.)

Does the pain travel to other parts of the body? \_\_\_\_\_

When did it occur? \_\_\_\_\_ How did it occur? \_\_\_\_\_

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

Have you seen other health professionals for this concern? Yes/No  
If yes, whom, and what treatment did they use? \_\_\_\_\_

Have you taken medication for this complaint? Yes/No

Have you ever experienced this complaint before? Yes/No If yes, when? \_\_\_\_\_

Did you receive any treatment at the time for this complaint? Yes/No

Have you had x-rays in relation to the current complaint? Yes/No

Is this an injury that occurred at work? Yes/No If yes, was it reported? Yes/No

Is this an injury as a result of a motor vehicle accident? Yes/No If yes, is there a claim pending? Yes/No

Do you have any known allergies to oils or skin creams? Yes/No \_\_\_\_\_

Have you been to a chiropractor previously? Yes/No  
If yes, when was your last treatment? \_\_\_\_\_

Have you been to a massage therapist previously? Yes/No  
If yes, when was your last treatment? \_\_\_\_\_

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How far along into your pregnancy are you? \_\_\_\_\_

When is your baby's due date? \_\_\_\_\_

Have you experienced any trauma during this pregnancy? \_\_\_\_\_

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?

Dates and Reasons:

\_\_\_\_\_  
\_\_\_\_\_

Have there been any stressful events in your life during this pregnancy?

\_\_\_\_\_  
\_\_\_\_\_

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What type of birth care provider are you planning on using?

- Midwife  OB/Gyn  Medical Doctor  Other

Where do you plan on delivering? \_\_\_\_\_

Is this your first pregnancy? Yes/No

If not, how many pregnancies previously? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

How many vaginal deliveries? \_\_\_\_\_

How many caesarean sections? \_\_\_\_\_

Have there been any complications during your previous deliveries? Yes/No \_\_\_\_\_

Was labor induced/use of Pitocin? Yes/No/Unknown

Did your care provider rupture your membranes? Yes/No/Unknown

Was there any back pain during labor? Yes/No

Did you receive an epidural? Yes/No

Were there any operative devices used? Yes/No  Forceps  Vacuum

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

- |   |   |
|---|---|
| <input type="checkbox"/> Nausea/"Morning Sickness"                  | <input type="checkbox"/> Pain down Posterior Leg (sciatica) |
| <input type="checkbox"/> Headaches                                  | <input type="checkbox"/> Heartburn/Indigestion              |
| <input type="checkbox"/> Carpal Tunnel (numbness in hands/fingers)  | <input type="checkbox"/> Constipation                       |
| <input type="checkbox"/> Pins/Needles in the Front Side of your Leg | <input type="checkbox"/> Swelling of Ankles, Legs and Feet  |
| <input type="checkbox"/> Pain in your Pubic Bone                    | <input type="checkbox"/> Hemorrhoids                        |
| <input type="checkbox"/> Leg Cramps                                 | <input type="checkbox"/> Facial Paralysis                   |
| <input type="checkbox"/> Breech Presentation                        | <input type="checkbox"/> Gestational Diabetes               |
| <input type="checkbox"/> Chronic Fatigue                            | <input type="checkbox"/> Low/Mid Back Pain                  |

Are you interested in:

- Acute Pain Care: We can provide relief for the immediate pain you are feeling. It is important to remember that your body is constantly changing and adapting for the duration of your pregnancy and you are likely to experience a reoccurrence of this pain.
- Maintenance Care: We can provide ongoing care for the duration of your pregnancy to prevent your pain from getting worse if it returns.
- Wellness Care: We can provide ongoing care for the duration of your pregnancy to prevent your pain from getting worse if it returns, as well as prevent many other common conditions associated with pregnancy. Wellness care has also been shown to reduce labour times and intensity of pain for women who are adjusted on a regular schedule.
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## 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: \_\_\_\_\_