

Patient Intake Form

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 our practitioners contact you personally via email regarding your care? Yes/No

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

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

Occupation: _____ Do you primarily sit or stand at work? _____

Emergency Contact

Name: _____ Phone: _____

Relationship to you: _____

Family Doctor

Name: _____ Phone: _____

Address: _____

Date of last appt/physical: _____

May we communicate with your family doctor regarding your care at Village Wellness? Yes/No

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: _____

May we communicate with your other health care professionals regarding your care at Village Wellness?
Yes/No

What is your current Height? _____ Weight? _____

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

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 _____

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
(type I or type II) | <input type="checkbox"/> Breathing or Lung Problems
(e.g. asthma) | <input type="checkbox"/> Neurological Conditions
(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?

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?

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: _____

Chiropractic and Massage Patient Intake Form

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? _____

Are you interested in:

Acute Pain Care Maintenance Care Wellness Care

If you are unsure which type of care is right for you, please discuss this with your health care practitioner.

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: _____