



## Practice Member Information

File \_\_\_\_\_

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

Appointment Date D \_\_\_\_\_ M \_\_\_\_\_ 20 \_\_\_\_\_ Birth Date D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

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

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

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

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

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

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

Spouse's name? \_\_\_\_\_

Name(s) and age(s) of children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you primarily: Sit Stand Perform repetitive tasks

How did you hear about us? \_\_\_\_\_

## Healthcare History

Have you had previous chiropractic care? No Yes

Who was your previous Chiropractor? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

Were X-rays taken in the last 6 months? Yes No

What was the primary reason for consulting that office?

- Relief Care - Symptom relief of pain or discomfort
- Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
- Wellness Care - Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? No Yes

Please explain: \_\_\_\_\_

Are you wearing: Heel Lifts Custom Orthotics

Family Doctor: \_\_\_\_\_

Date and reason of last visit: \_\_\_\_\_

May we contact your family doctor regarding your care at our office if necessary? No Yes

Naturopathic Doctor: \_\_\_\_\_

Date and reason of last visit: \_\_\_\_\_

**Other Specialists and healthcare professionals:**

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

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

Date and reason of last visit: \_\_\_\_\_

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

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

Date and reason of last visit: \_\_\_\_\_

**Pregnancy Profile**

How far along in your pregnancy are you? \_\_\_\_\_ When is your baby's due date? D \_\_\_\_ M \_\_\_\_ Y \_\_\_\_

Have you taken any medications during this pregnancy? No Yes:

OTC and Reason: \_\_\_\_\_

Prescription and Reason: \_\_\_\_\_

Vaccines and Reason: \_\_\_\_\_

Have you experienced any physical trauma during this pregnancy? No Yes \_\_\_\_\_

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? No Yes

Dates and Reasons: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have there been any stressful events in your life during this pregnancy? No Yes \_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_

Miscarriages? No Yes: D&C Natural Miscarriage

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

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

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

Was labor induced/use of Pitocin? No Yes Unknown

Did your care provider rupture your membranes? No Yes Unknown

Was there any back or hip pain during labor? No Yes

Was baby in a suboptimal position during the pushing phase of any labor? No Yes Unknown

Did you receive an epidural? No Yes

Were there any operative devices used? No Yes Forceps Vacuum

Any postpartum complications or long term consequences? No Yes \_\_\_\_\_

\_\_\_\_\_

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

CURRENT  
PREVIOUS

- Headaches
- Facial Paralysis
- Chronic Fatigue
- Nausea/"Morning Sickness"
- Heartburn/Indigestion
- Preeclampsia
- Gestational Diabetes
- Constipation
- Hemorrhoids

CURRENT  
PREVIOUS

- Carpal Tunnel (numbness in hands/fingers)
- Low/Mid Back Pain
- Breech or Sidelying Presentation
- Round Ligament Pain/Pulling (front of belly)
- Pain in your Pubic Bone
- Pins/Needles in the Front/Side of your Leg
- Pain in Posterior Leg (Sciatica)
- Leg Cramps
- Swelling of Ankles, Legs and Feet

## Wellness Profile

Do you have a specific concern that brings you in?

No, I'm interested in having my spinal and pelvic alignment assessed to help achieve optimal growth and delivery for my baby

Yes: \_\_\_\_\_

**If yes, please answer the following questions:**

What is your primary area of complaint today? \_\_\_\_\_

How long have you been aware of this? \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

Where else does this pain go in your body? \_\_\_\_\_

How often do you experience this? daily weekly monthly comes and goes constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? \_\_\_\_\_

How would you describe the pain/discomfort?

Dull Achy Throbbing Stabbing Tight/Stiff Burning Sharp Other \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

Do you notice any other problems in your body when you get this pain/discomfort? \_\_\_\_\_

Do you feel your condition getting progressively worse? No Yes

Do you feel your condition can be healed? No Yes

What have you tried that **has** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other \_\_\_\_\_

What have you tried that **hasn't** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other \_\_\_\_\_

See additional **Spinal Nerve Function Form** to provide further detail on your *Wellness Profile (Page 6)*

## Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a **Vertebral Subluxation**. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

## Physical

Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you happy with your current physical appearance and abilities? Yes No

Frequency of exercise/week: Cardio? . . . . 0 1 2 3 4 5 6 7

Weight bearing?. 0 1 2 3 4 5 6 7

Do you stretch after exercise or after other activities of poor posture? Yes Sometimes No

Hours of sleep/night? <6 7-9 10+

Do you feel refreshed upon waking? Always Sometimes Rarely

Age of mattress? \_\_\_\_\_ Do you feel your mattress is appropriate for your sleeping style? No Yes

Which position do you sleep? Back Belly Side: Right Left Both

Number of hours spent commuting/week? 0-2 3-5 6-8 9-11 12+

Number of hours spent at a desk or computer/week? 0 1-5 6-10 11-20 21-40 41+

Number of hours spent on smart device/tablet/week? 0 1-5 6-10 11-20 21-40 41+

Do you perform any repetitive tasks at home or at work? No Yes

Have you ever been hospitalized or had surgery? No Yes If yes why and when? \_\_\_\_\_

Have you ever been in a motor vehicle accident (even if it was minor)? No Yes

If yes, what kind and when? \_\_\_\_\_

Were you evaluated and treated after each accident? No Yes

Have you had any non-vehicle accidents or falls? No Yes \_\_\_\_\_

### Early Years

To your knowledge, was your delivery difficult? No Yes  
 If yes: Forceps Vacuum Caesarean Breech Other \_\_\_\_\_  
 Were you breast fed? No Yes For how long? \_\_\_\_\_  
 Did you experience emotional trauma as a child? No Yes \_\_\_\_\_  
 Were you ever given antibiotics as a child? No Yes \_\_\_\_\_  
 Did you ever have ear infections as a child? No Yes \_\_\_\_\_  
 Any major childhood illness? No Yes \_\_\_\_\_

### Emotional

Rate your current level of **personal stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **relationship stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **financial stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **health stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **family stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **career stress** in your life: . . . . . None Low Moderate High  
 Do you feel you have a supportive network of friends and family? . . . . Yes No  
 Do you feel you have healthy coping strategies for life stress? . . . . . Yes No

### Chemical

Were you vaccinated as a child? . . . . . No Yes  
 Any adverse reactions to vaccines? . . . . . No Yes \_\_\_\_\_  
 Do you choose to have annual flu shots? . . . . . No Yes  
 Do you take antibiotics? . . . . . No Yes, How often? \_\_\_\_\_  
 How many glasses of water/day: . . . . . 0 1-3 4-6 7-9 10+  
 How many glasses of caffeinated beverages/day: . . . . . 0 1-3 4-6 7-9 10+  
 How many glasses of cow's milk, juice and pop/day: . . . . . 0 1-3 4-6 7-9 10+  
 Do you eat gluten? . . . . . No Yes Trying to eliminate from diet  
 Do you eat dairy? . . . . . No Yes Trying to eliminate from diet  
 Do you eat refined sugars? (white sugar, white bread and pasta) . . . . . No Yes Trying to eliminate from diet  
 Do you eat boxed/frozen foods? . . . . . No Yes Trying to eliminate from diet  
 Do you choose organic foods? . . . . . No Yes, which: Veggies Fruits Meats Grains All  
 Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . . . . . No Yes  
 Any food/drink allergies, sensitivities, intolerances? . . . . . No Yes \_\_\_\_\_  
 Do you smoke? . . . . . No Yes I used to for\_\_ years I wish I didn't  
 Are you or have you been exposed to second hand smoke? . . . . . No Yes  
 Do you drink alcohol? . . . . . No Yes 0-6/week 6-12/week 12+/week  
 Do you take a probiotic daily? . . . . . No Yes, \_\_\_\_\_CFU's/day  
 Do you take vitamin D3 daily? . . . . . No Yes, \_\_\_\_\_IU's/day  
 Do you take Omega 3 Fish Oils daily? . . . . . No Yes, \_\_\_\_\_mg/day Capsule Liquid  
 Other supplements or homeopathics? \_\_\_\_\_  
 Any other daily medication and their purpose? \_\_\_\_\_

Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? No Yes

**Family Health**

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: \_\_\_\_\_

Spouse: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_

Are you seeking chiropractic care today for:

Relief Care - Symptom relief of pain or discomfort

Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

Wellness Care - Maximizing the body's ability for optimal healing and function

Pregnancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a healthy delivery and fast recovery.

Do you have other concerns we should know about? \_\_\_\_\_

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

**Goals & Consent**

What is your primary goal for consulting our clinic? \_\_\_\_\_

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I \_\_\_\_\_ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

\_\_\_\_\_  
Consenting Adult's Signature

\_\_\_\_\_  
Date



## Financial and Cancellation Policy

The doctors and staff at Village Wellness are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment with us. Please initial next to each section to confirm your understanding and acceptance of our policies:

### **FEE FOR SERVICE**

Village Wellness is a fee for service facility and we require payment at the time of your visit, with the exception of a limited number of companies for which direct billing is available (see below). Many services are covered in part or in full by third party insurance; however, it is ultimately the responsibility of the patient to ensure payment is made at the time of service. Our recommendations for care are based upon our desire to see you get and stay well, despite your level of coverage. Insurance plans or coverage maximums are in no way related to your health but rather are functions of a financial arrangement between you and your insurance provider.

### **PRIVATE INSURANCE COVERAGE**

Your insurance policy is a contract between you and your insurance company, not between your insurance company and our office. Please take the time to verify your coverage for chiropractic, massage therapy and/or orthotics with your insurer by contacting them prior to your first visit. Please also inquire and obtain any specific insurer required medical prescriptions for service. If you are choosing to submit receipts for reimbursement Village Wellness will provide you with appropriate payment receipts for your reimbursement either at each visit or after multiple appointments depending on your preference.

### **DVA / RCMP**

Direct billing is currently offered to DVA / RCMP patients. If you exhaust your coverage prior to authorization of an extension request, then you are responsible for any of your services received outside of your original coverage. **IF FOR ANY REASON, DVA OR RCMP WILL NOT APPROVE YOUR CLAIM, YOU SHALL ULTIMATELY BE RESPONSIBLE FOR ALL CHARGES INCURRED.**

### **MOTOR VEHICLE PATIENTS**

In order to provide direct billing service under the Nova Scotia Motor Vehicle Act, you must abide by the requirements of the approved section B protocols, which may involve exhaustion of your private insurance coverage (depending on your individual circumstances). **IF FOR ANY REASON, YOUR MOTOR VEHICLE INSURER WILL NOT ACCEPT YOUR CLAIM; YOU SHALL ULTIMATELY BE RESPONSIBLE FOR ALL CHARGES INCURRED.**

### **WORKER'S COMPENSATION PATIENTS**

If you are injured on the job, you will need to inform your employer of the accident and obtain a WCB claim number prior to direct billing by Village Wellness. **IF FOR ANY REASON, WCB WILL NOT ACCEPT YOUR CLAIM; YOU SHALL ULTIMATELY BE RESPONSIBLE FOR ALL CHARGES.**

<i>*For your convenience we accept the following forms of payment:</i>	<b>EXACT CASH</b>	<b>Debit</b>	<b>Visa</b>	<b>Master Card</b>	<b>AMEX</b>
--	-------------------	--------------	-------------	--------------------	-------------



## Financial and Cancellation Policy

<u>Chiropractic</u>	
Initial Chiropractic Examination - Includes Day 1 Health History, Computerized Spinal Scan Analysis, Physical Examination, X-rays (if indicated), Day 2 Detailed Report of Findings, First Adjustment, Wellness Workshop attendance for you and a guest	\$140
Subsequent Chiropractic Visit	\$50
New Complaints / Re-evaluations	\$90

<u>Massage Therapy</u>	
30 Minute Massage (specific area only)	\$55.20
45 Minute Massage	\$72.45
60 Minute Massage	\$89.70
90 Minute Massage	\$143.75
<i>**Massage Therapy Prices include 15% HST</i>	

<u>Orthotics</u>	
Custom Orthotic Inserts	\$360
Custom Orthotic Shoes (with inserts included)	\$460
Initial Orthotic Appointment (current practice member)	\$50
Initial Orthotic Appointment (new practice member)	\$90
Fitting/Adjustment Appointment	\$50

<b>Cancellation Policy Regarding Massage Therapy and Initial Chiropractic Visits</b>
Our therapists, at Village Wellness, are often scheduled well in advance for appointments. We always seek to be on time to respect your valuable time. We ask that you respect the time we are holding for you as well. We hope you understand that it is a hardship for us and that we must charge a small fee in the event of a no show or last minute cancellation.
<b>·NO SHOW / CANCELLATION FEE (less than 24hrs)→ \$25.00·</b> <b>·LATE ARRIVAL → The FULL scheduled massage appointment will be charged·</b>
As a courtesy, when time allows, we make reminder calls for Massage and Initial Chiropractic appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

<b>Hours of Operation</b>				
	Chiropractic		Registered Massage Therapy	Clinic Hours
Monday	7am – 9:30am	2pm – 6:30pm	7am – 8pm	7am-8pm
Tuesday	7am – 10am	4pm – 6pm	8am – 8pm	7am-8pm
Wednesday		2pm – 6:30pm	9am – 8pm	9am-8pm
Thursday	8am – 11am		9am – 8pm	8am-8pm
Friday	7am – 11am		8am – 4pm	7am-4pm

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_