Village Wellness

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Pregnancy
Wellness Profile

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		CURRENT	PREVIOUS	
☐	☐	Headaches	☐	☐	Carpal Tunnel (numbness in hands/fingers)
☐	☐	Facial Paralysis	☐	☐	Low/Mid Back Pain
☐	☐	Chronic Fatigue	☐	☐	Breech or Sidelying Presentation
☐	☐	Nausea/"Morning Sickness"	☐	☐	Round Ligament Pain/Pulling (front of belly)
☐	☐	Heartburn/Indigestion	☐	☐	Pain in your Pubic Bone
☐	☐	Preeclampsia	☐	☐	Pins/Needles in the Front/Side of your Leg
☐	☐	Gestational Diabetes	☐	☐	Pain in Posterior Leg (Sciatica)
☐	☐	Constipation	☐	☐	Leg Cramps
☐	☐	Hemorrhoids	☐	☐	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* (***Page6***)

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
- ☐ Pregancy 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

Village Wellness

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.***

**For your convenience we accept the following forms of payment:*	**EXACT CASH**	**Debit**	**Visa**	**Master Card**	**AMEX**

*These terms and conditions are subject to change without notice. 2016

Village Wellness

Financial and Cancellation Policy

Chiropractic	
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

Massage Therapy	
30 Minute Massage (specific area only)	$55.20
45 Minute Massage	$72.45
60 Minute Massage	$89.70
90 Minute Massage	$143.75
***Massage Therapy Prices include 15% HST*	

Orthotics	
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

Cancellation Policy Regarding Massage Therapy and Initial Chiropractic Visits

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.

·NO SHOW / CANCELLATION FEE (less than 24hrs)→ $25.00·
·LATE ARRIVAL → The FULL scheduled massage appointment will be charged·

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.

Hours of Operation

	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:_____

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