Village Wellness

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**.

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

Women Only

- ☐ Severe Menstrual Cramps
- ☐ Hot Flashes
- ☐ Loss of Menstruation
- ☐ Irregular Cycles

Family History

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

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes (type I or type II)
- ☐ Stroke
- ☐ Heart Disease
- ☐ Thyroid Problems
- ☐ Hormone Problems
- ☐ Breathing or Lung Problems (e.g. asthma)
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Neurological Conditions (e.g. ALS, MS, Parkinson's, CP, TBI)
- ☐ Mental Illness
- ☐ Depression
- ☐ I do not know my family medical history.
- ☐ 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: ___________________________

Village Wellness

Chiropractic and Massage Patient Intake Form

Primary Complaint:

What is your current concerm? ____

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

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.

Village Wellness

Financial and Cancellation Policy

Chiropractic	
Initial Chiropractic Examination	$140
- 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	
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 Hours		Registered Massage Therapy Hours	Clinic Hours
Monday	7am – 9:30am	2pm – 6:00pm	12:45pm – 8pm	7am - 8pm
Tuesday	7am – 10am		7am – 6:15pm	7am - 8pm
Wednesday		2pm – 6:30pm	12:45pm – 8pm	10am - 8pm
Thursday			8:15am – 6:15pm	8am - 8pm
Friday	7am – 11am		7am – 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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