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)
- ☐ Thyroid Problems
- ☐ Hormone Problems
- ☐ Breathing or Lung Problems (e.g. asthma)
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Neurological Conditions (e.g. ALS, MS, Parkinson's, CP, TBI)
- ☐ Stroke
- ☐ Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ 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: _____

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

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. 2023

Village Wellness

Financial and Cancellation Policy

Chiropractic	
Initial Chiropractic Examination	$150
- Includes Health History, Computerized Spinal Scan Analysis, Physical Examination, X-rays (if indicated) and Detailed Report of Findings	
Subsequent Chiropractic Visit	$60
New Complaints / Re-evaluations	$90

Massage Therapy	
30 Minute Massage (specific area only)	$63.25
45 Minute Massage	$86.25
60 Minute Massage	$103.50
90 Minute Massage	$166.75
***Massage Therapy Prices include 15% HST*	

Orthotics	
Custom Orthotic Inserts	$360
Custom Orthotic Shoes (with inserts included)	$460
Initial Orthotic Appointment (current practice member)	$60
Initial Orthotic Appointment (new practice member)	$90
Fitting/Adjustment Appointment	$60

Naturopathic Medicine	
Naturopathic Initial Visit - Adult	$210
Naturopathic Initial Visit - Child	$210
Naturopathic Re-Assessment Visit	$165
Naturopathic Follow Up Visit	$100
Naturopathic Extended Follow Up Visit	$135
Naturopathic Injection Visit	$25

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)→ Up to the full amount of your scheduled visit·
·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.

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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