Village Wellness

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villagewellness.com

Pediatric

School Aged Children

Patient Information

File _____

Child's Name: _____ D _____ M _____ Y _____
Parent's/Guardian's Names: _____
Home Address: _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Work Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Email: _____
May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)
How did you hear about us? _____
Height (of child): _____ Weight (of child): _____ Birth Date: D _____ M _____ Y _____ Age: _____ Sex: ☐ M ☐ F
Siblings and ages: _____ _____ _____ _____
Previous Chiropractic Care? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship to child: _____
Phone number: _____ Alternate phone number: _____

Family Doctor

Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
May we communicate with your family doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals

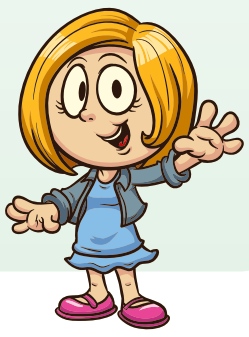
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

- ☐ He/She is continuing ongoing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.



Wellness Profile

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.*** Many of the common health challenges that adults experience have their origins during the ***developmental years,*** some starting at birth. Layers of damage to the spine and ***nervous system*** occur as a result of various ***traumas, toxins and emotional stress.*** The result may be misalignment to the spinal column and damage to the nervous system in a condition called ***Vertebral Subluxation.*** Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal.***

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivites	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PPD

Do you have a specific concern that brings you in?

☐ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.

☐ Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____

Is it getting better, worse or staying the same? _____ Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint?

☐ No ☐ if Yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? . . . . . ☐ No ☐ Yes _____

Has your child ever experienced this complaint before? . . . . . ☐ No ☐ Yes _____

Did they receive any treatment at the time? . . . . . ☐ No ☐ Yes _____

Has your child had x-rays in relation to the current complaint? . . ☐ No ☐ Yes _____

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy: ☐ No ☐ Yes (Brief description) _____

Ultrasounds during pregnancy: ☐ No ☐ Yes, if so, how many? _____

Medications during pregnancy: ☐ No ☐ Yes _____

If so which ones and how often? (include OTC): _____

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: ☐ No ☐ Yes _____

Birth Experience

Location of Birth: ☐Home ☐Hospital ☐ Birthing Centre ☐Other _____
Birth Attendants: ☐Doula ☐Midwife ☐GP ☐OB ☐Other _____
Medications during labor / delivery (including IV antibiotics) ☐No ☐ Yes_____
Was Pitocin used to induce / speed up labor? ☐ No☐ Yes
Were your membranes ruptured by a medical professional? ☐No ☐ Yes
Was your child at anytime during your pregnancy in an intra-uterine constraining position? ☐No ☐Yes ☐Unsure
If yes, please describe: ☐Breech ☐Transverse ☐Face / Brow presentation
Was your delivery vaginal or C-section? _____ If it was a C-section, was it planned or emergency? _____
If it was vaginal, was the baby presented: ☐Head ☐Face ☐Breech
Were any of the following interventions used during delivery? ☐Forceps ☐Vacuum Extraction ☐Other
Were there any complications during delivery? ☐Yes ☐No
If yes, please specify:_____
How long was the labor from the first regular contractions to the birth? _____ Hours
How long was the second stage (the pushing phase) of the labor?_____ Hours
Was the baby born with any purple markings / bruising on their face or head? ☐No ☐Yes
Any concerns about misshapen head at birth? ☐No ☐Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ___w ___d / Birth Weight: ___lbs___oz / Birth Length: ____Inches
If known, APGAR scores at: 1 minute_____ /10 5 minutes _____ /10
Was the baby ever administered to Neonatal Intensive Care? ☐No ☐ Yes
If yes, for how long and why?_____
Was any medication given to the baby at birth? ☐Yes ☐No ☐Unsure
If yes, what medication and why? _____
Was your child exclusively breastfed? ☐No ☐Yes _____months
Was your child breastfed + formula fed? ☐No ☐Yes_____months
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐No ☐Yes
What age did you introduce solid foods to your child?_____ months
Did you introduce cereal or grains within your child's first year? ☐No ☐Yes
Did/Do you practice attachment parenting methods:
(cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) ☐No ☐Yes
Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats etc?
☐No ☐Yes, Which ones? _____

Physical Traumas

Has your child ever fallen from any high places? . . . . . ☐No ☐Yes_____
Has your child ever been involved in a motor vehicle accident or near miss? . . . . . ☐No ☐Yes_____
Has your child been seen on an emergency basis? . . . . . ☐No ☐Yes_____
Has your child broken any bones?. . . . . ☐No ☐Yes_____
Has your child had any previous hospitalizations?. . . . . ☐No ☐Yes_____
Has your child had any previous surgeries? . . . . . ☐No ☐Yes_____
Does your child spend time using a tablet, computer or video games?. . ☐Never ☐Rarely ☐Daily ☐Several hrs/day
Does your child watch tv? . . . . . ☐Never ☐Rarely ☐Daily ☐Several hrs/day
Does your child exercise? . . . . . ☐No ☐Daily ☐Weekly ☐Seasonally
Does your child play contact sports? . . . . . ☐No ☐Daily ☐Weekly ☐Seasonally
Does your child sleep on their . . . . . ☐Back ☐Belly ☐Sides (Both, Right, Left)
Does your child carry a back back? . . . . . ☐No ☐Yes
Does it weigh less than 15% of their body weight? . . . . . ☐No ☐Yes
Do they wear their back pack on 2 shoulders? . . . . . ☐No ☐Yes ☐Sometimes
Does your child show excessive or uneven shoe wearing out? . . . . . ☐No ☐Yes
Does your child wear custom orthotics?
☐No ☐Yes, For what purpose? _____

Chemical Stressors

Have you chosen to vaccinate your child? ☐No ☐Yes, on a delayed or selective schedule ☐Yes, on schedule
Reaction(s) to vaccination: ☐Fever ☐Welt at injection site ☐Rash ☐Diarrhea ☐Fatigue ☐Prolonged Cry
☐Seizures ☐Developmental Regression ☐Other _____
Does your child receive annual flu shots? ☐No ☐Yes (informed decision) ☐Yes (recommended by MD)
Has your child been exposed to antibiotics? ☐No ☐Yes
If yes, how many doses in past 6 months? _____Reason _____
Were probiotics used at the same time as antibiotics? ☐No ☐Yes
Has your child been exposed to medications, including OTC: ☐No ☐Yes
If yes, which ones? _____
If yes, how many doses in past 6 months? _____Reason _____
How many glasses of water/day does your child have? . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and soda/day does your child have: . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Does your child eat gluten? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat dairy? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta? . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods? ☐No ☐Yes If yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? ☐No ☐Yes
Does your child follow any other dietary restrictions? ☐No ☐Yes _____
Any food/drink allergies, sensitivities, intolerances? ☐No ☐Yes _____
Is your child exposed to second hand smoke? ☐No ☐Yes _____
Does your child take a probiotic daily? ☐No ☐Yes:_____ CFU's/day
Does your child take vitamin D3 daily? ☐No ☐Yes:_____ IU's/day
Does your child take Omega 3 Fish Oils daily? ☐No ☐Yes: _____mg/day ☐Capsule ☐Liquid
Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age:
Intellectually: ☐Yes ☐No _____
Emotionally: ☐Yes ☐No _____
Physically: ☐Yes ☐No _____

What is your primary goal for your child at our clinic? _____

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

Consent to Evaluation of a Minor Child
I _____being the parent or legal guardian of_____,
(print name of consenting adult) (print name of minor)
hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. 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. 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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