



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 Welp 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



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>	Cash	Debit	Visa	Master Card	AMEX
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Financial and Cancellation Policy

<u>Chiropractic</u>	
Initial Chiropractic Examination - Includes Health History, Computerized Spinal Scan Analysis, Physical Examination, X-rays (if indicated) and Detailed Report of Findings	\$150
Subsequent Chiropractic Visit	\$65
New Complaints / Re-evaluations	\$90

<u>Massage Therapy</u>	
30 Minute Massage (specific area only)	\$68.40
45 Minute Massage	\$96.90
60 Minute Massage	\$114.00
90 Minute Massage	\$171.00
<i>**Massage Therapy Prices include 14% HST</i>	

<u>Orthotics</u>	
Custom Orthotic Inserts	\$360
Custom Orthotic Shoes (with inserts included)	\$460
Initial Orthotic Appointment (current practice member)	\$65
Initial Orthotic Appointment (new practice member)	\$90
Fitting/Adjustment Appointment	\$65

<u>Chiropractic Pre-Pay Plans</u>	
Pre-Pay plans are available for individuals or families. Minimum 10 visit commitment. Savings of \$10 per visit compared to regular chiropractic visits.	

Cancellation Policy Regarding Massage Therapy and Initial Chiropractic Visits
<p>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.</p> <p>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 fee in the event of a no show or last minute cancellation.</p> <hr/> <p>·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·</p> <hr/> <p>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.</p>

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: _____