KAURI
CHIROPRACTIC

Fee Policy

Initial Consultation Adult - $85

Initial Consultation Child - $75

Regular Health Check-up Adult - $50

Regular Health Check-up Child - $45

Progress/Re-Examination Adult - $65

Progress/Re-Examination Child - $55

Cancellation Policy

Kauri Chiropractic accepts cancellations until 24 hours of your scheduled appointment. Beyond this Kauri Chiropractic reserves the right to charge the practice member in full for the appointment time. Unless it's an emergency, a strict 'no show' fee is in place where if that practice member fails to turn up for a scheduled appointment, without prior notice, payment for the service will be charged in full.

Refund Policy

Any unused prepaid visit fees will be refunded promptly (within three (3) business days) upon request or may remain as a credit towards future visits if you wish. You may decide at any time not to continue your prepayment billing arrangement, subject to payment of office visits that have already occurred, without financial penalty.

Signature_____ Chiropractor_____

New Practice Member Health Profile

Name _____ DOB _____ Age _____ M / F

Address _____ City _____ Prov _____ Postal Code _____

Primary Health Care Provider _____ Contact # _____

Ph. Home_____ Cell_____ Email _____

Do you prefer Text OR Email reminders? ☐ TEXT DAY OF ☑ EMAIL TWO DAYS BEFORE

Occupation _____ Employer _____

Single / Common Law / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Name, Age, Gender (M/F) _____

_____

Have they had a spine check-up? YES / NO

Emergency Contact Name _____ #_____ Relationship _____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Pain Intensity 0 = No Pain 10 = Unimaginable	When did this episode start?	If you had this problem before, when?	Did the problem begin with an injury?	Are the symptoms Constant or Intermittent?	Type of Pain *Refer to Legend below
1. _____	_____	_____	_____			
2. _____	_____	_____	_____			
3. _____	_____	_____	_____			
4. _____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____		_____	

* For "Type of Pain" Refer to this legend and use the corresponding letter(s)

S = **S**harp/**S**tabbing, **T = T**ingling, **D** = **D**ull, **B** = **B**urning, **A** = **A**ching, **N** = **N**umbness, **R** = **R**adiating, **W** = **W**eakness, **St** = **St**iffness, **Th** = **Th**robbing, **Sp** = **Sp**asm

Does the pain travel? (i.e. down legs / into fingers) _____

What relieves your symptoms? _____

What makes your symptoms worse? _____

When are your symptoms the worst? (i.e. morning / night) _____

Have you seen other providers for these concerns? ◯ YES / NO ◯ If YES, Who ↓

Chiropractor _____ Medical Doctor _____ Other _____

Results _____

Please mark "P" for in <u>THE PAST</u> OR mark "C" for <u>CURRENTLY HAVE</u>

___ ADHD
___ Allergies
___ Anxiety
___ Arm Pain
___ Arthritis/Joint Pain
___ Asthma
___ Autism
___ Autoimmune Issues
___ Bed Wetting
___ Bladder Problems
___ Chest Pain
___ Constipation
___ Depression
___ Diarrhea
___ Difficulty Breathing
___ Digestive Issues
___ Disc Problems
___ Dizziness
___ Double/Blurry Vision
___ Ear Infections
___ Epilepsy
___ Fibromyalgia
___ Foot Pain
___ Frequent Colds
___ GERD/Gastric Reflux
___ Headaches
___ Hearing Loss
___ Heart Problems
___ High/Low Blood Pressure
___ Hip/Leg Pain
___ Infertility
___ Insomnia
___ Jaw/TMJ Pain
___ Kidney Problems
___ Knee Pain
___ Loss of Balance
___ Loss of Energy
___ Low Back Pain
___ Memory Loss
___ Menstrual Problems
___ Mid Back Pain
___ Migraines
___ Nausea
___ Neck Pain
___ Nervousness
___ Numb/Tingling in Arms/Hands
___ Numb/Tingling in Legs/Feet
___ Poor Posture
___ Prostate Problems
___ Ringing in the Ears
___ Sciatica
___ Scoliosis
___ Seizures
___ Sexual Dysfunction
___ Shoulder Pain
___ Sinus Issues
___ Skin Problems
___ Sleep Apnea
___ Sports Injury
___ Stomach Problems
___ Thyroid Issues
___ Tight/Sore Muscles
___ Tremors
___ Ulcers
___ Upper Back Pain

Others _____

Please mark "P" for in <u>THE PAST</u> OR mark "C" for <u>CURRENTLY HAVE</u>

___ Brain Injury
___ Cancer
___ Stroke
___ Concussion
___ Diabetes
___ Disability
___ Dislocations
___ Heart Attack
___ Rheumatoid Arthritis
___ Scoliosis
___ Spinal Fracture
___ Spinal Surgery
___ Tumors
___ Other Serious Condition: _____

List all surgical operations & years _____

List any other injuries, minor or major _____

Have you ever been in a car accident? **List all** _____

Have you ever been knocked unconscious? ◯ YES / NO ◯ Fractured a Bone? ◯ YES / NO ◯

If YES, Please Describe _____

List all over-the-counter, prescription medications, supplements you are on & the reason for each

_____

Spinal health is especially important during pregnancy & post-partum. If female, are you pregnant?
(Please Tick)

☐ YES Due Date _____ ☐ NO ■ MAYBE / UNSURE

Social History Do you: (Please Circle)

☐ Smoke / ☐ Vape / ☐ Use Tobacco / ☐ Use Marijuana or ☐ Nicotine Products

if YES, How often _____ How much _____

Consume Alcohol if YES, How often _____ How much _____

Consume Coffee / Tea / Soft Drinks if YES, How often _____ How much _____

Exercise if YES, How often _____ How much _____

Circle which best describes your Quality of SLEEP **Poor** **Fair** **Good** **Excellent**

Circle which best describes your EATING habits **Poor** **Fair** **Good** **Excellent**

Are there any other **physical, chemical, or emotional** stressors that you think may be affecting you in any way**?** _____

How does your present problem affect the following HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE

_____

CIRCLE WHAT DAILY ACTIVITES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS

☐ Carrying / Lifting Groceries	☐ Driving	☐ Reading / Concentration	☐ Yard Work
☐ Family Time	☐ Extended Computer Use	☐ Sweeping / Vacuuming	☐ Bathing
☐ Climbing Stairs	☐ Dressing	☐ Sitting	☐ Work/Job
☐ Lifting Children	☐ Shaving	☐ Standing	☐ Laundry
☐ Sleeping	☐ Walking	☐ Sexual Activities	☐ Sports

Other _____

Have you had previous chiropractic care**?** YES / NO

If YES, Dr. & Date _____

Were X-rays Taken**?** YES / NO If YES, Date _____

What are your Health Goals? _____

I would like to experience the following benefits from Chiropractic Care (Please Tick)

☐ Correction ☐ Prevention of Future Problems ☐ Increase Quality of Life

☐ Increased Energy Levels ☐ Increased Quality of Sleep ☐ Clarity of Mind

☐ Increased Mobility ☐ Stronger Immune System ☐ Optimal Health on all Levels

_____ _____ _____

Name Signature Date

Family Health Profile

This form is to assist the doctor by providing family history information for their review

	Spouse	Children	Mother	Father
Abnormal Posture	☐	☐	☐	☐
Acid Reflux	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐
Anxiety / Nervousness	☐	☐	☐	☐
Arthritis / Joint Pain	☐	☐	☐	☐
Asthma / Breathing Difficulties	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐
Autoimmune Disorders	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐
Bed Wetting	☐	☐	☐	☐
Blurred / Double Vision	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Carpal Tunnel	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Digestive / Stomach Problems	☐	☐	☐	☐
Disc Problems	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
Frequent Colds / Illness	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Hearing Issues	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐
High- / Low- Blood Pressure	☐	☐	☐	☐
Hip / Leg Pain	☐	☐	☐	☐
Infertility	☐	☐	☐	☐
Jaw / TMJ Pain	☐	☐	☐	☐
Kidney Condition	☐	☐	☐	☐
Menstrual Problems	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐
Numbness / Tingling	☐	☐	☐	☐
Sciatica	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐
Shoulder Pain	☐	☐	☐	☐
Sinus Issues	☐	☐	☐	☐
Sleeping Difficulties	☐	☐	☐	☐
Stiffness	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Issues	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also have some level of risk. The level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: temporary worsening of symptoms, sprain/strain, irritation of a pre-existing disc condition, and rarely, fractures. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

Chiropractic care has been demonstrated to be effective for complaints of the neck, back and other areas of the body including organ dysfunction caused by nerves, muscles, joints and related tissues. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Prior to receiving chiropractic care in this practice, a health history and physical examination will be completed. These procedures are performed to assess your specific concerns, your overall health and in particular the state of your nerve system. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept the above information associated with chiropractic care and give consent to the examination and chiropractic care, including spinal adjustments after my findings have been reported. I have not signed this prior to having my questions or concerns addressed and discussed.

_____	_____	_____
Name	Signature	Date