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

Unless it's an emergency, a strict 'no show' fee is in place where if that patient fails to turn up for a scheduled appointment, without 24 hours' notice, payment for the service will be charged in full. Patients that are 10 minutes late past their scheduled appointment time are deemed "no shows" and will be charged for their appointment in full. Please note that if you are 10 minutes late and past your appointment time, you may no longer be able to be treated by the Chiropractor, and it is up to the clinic staffs discretion whether you will be able to proceed with an appointment. This policy is to respect all scheduling of patients who have appointments booked and the Chiropractors schedule. Staff want to work with you to reschedule your appointment, provided you give adequate notice.

Signature___________________________ Chiropractor___________________________

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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