Fee Policy

Initial Consultation Adult - $

Initial Consultation Child - $

[illegible]

[illegible]

Regular Health Check-up Adult - $5

Regular Health Check-up Child - $

Progress/Re-Examination Adult - $

Progress/Re-Examination Child - $

Progress eport dult 0

Progress Report Child - $60

Cancellation and "No Show" Policy

Kauri Chiropractic accepts cancellations until 24 hours of your scheduled appointment. Beyond this Kauri Chiropractic reserves the right to charge the patient in full for the appointment time. 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_____

New Practice Member Health Profile - Child

It is our pleasure to welcome you to our family of happy and healthy chiropractic members. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental and chemical) can interfere with your child's growing brain, spine and nervous system. To help us serve you better, please complete the following history information about your child. We look forward to working with you to build a better future for your family.

Name _____ DOB _____ Age _____ M / F

Address _____ City _____ Prov _____ Postal Code _____

Height _____ Weight _____ Parent / Guardian Name(s) _____

Ph. Home _____ Cell _____ Email _____

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

Who may we thank for referring you? _____

My child is here for:

☐ Wellness ☐ Overall Health Improvement ☐ Specific Health Concern(s) _____

Check any of the following that currently or previously apply:

☐ Abnormal Posture	☐ Back Pain	☐ Colic	☐ Headaches	☐ Temper Tantrums
☐ ADD / ADHD	☐ Bedwetting	☐ Constipation	☐ Language Delay	☐ Torticollis
☐ Allergies	☐ Behavioral Issues	☐ Digestive Problems	☐ Recurring Fevers	☐ Other _____
☐ Asthma	☐ Car Accident	☐ Ear Infections	☐ Scoliosis	_____
☐ Autism	☐ Chronic Colds	☐ Growing Pains	☐ Seizures	

How are these concerns affecting your child's quality of life? Please check all that apply:

☐ Attention/Focus	☐ Daily Routine	☐ Playing	☐ Sports
☐ Communication	☐ Eating	☐ School	☐ Walking
☐ Crawling	☐ Exercise	☐ Sleep	☐ Other _____

If there is a present health concern, how has it been progressing?

☐ Rapidly Improving	☐ Quickly Worsening	☐ About the Same
☐ Slowly Improving	☐ Gradually Worsening	☐ On and Off

Who else have you seen for the concern(s) ? _____

Previous chiropractic care? YES / NO If so, who and when? _____

Name of pediatrician _____ Last Visit _____

Are you satisfied with the care your child has received at the pediatrician? YES / NO

# of doses of antibiotics your child has taken in the past 6 months _____ Total in lifetime _____

Present prescription drugs / dosage _____

Previous prescription drugs / dosage _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc) _____

Prenatal & Birth History

Name of Obstetrician / Midwife _____

Complications during pregnancy / delivery? ◯YES / NO◯ Explain _____

Ultrasounds during pregnancy? ◯YES / NO◯ If so, How many? _____
Cigarette / alcohol use during pregnancy? ◯YES / NO◯
Medications taken during pregnancy / delivery _____

Location of birth: ☐ Hospital ☐ Birthing Centre ☐ Home
Birth Interventions: ☐ Forceps ☐ Vacuum Extraction ☐ Epidural ☐ Episiotomy
☐ Induction ☐ Manual Traction of neck ☐ C-Section ☐ None
If C-Section, was it? ☐ Emergency ☐ Planned

Duration of Labour _____

Genetic Disorders of Disabilities? ◯YES / NO◯ If yes, Please list _____

Birth weight _____ Birth length _____ APGAR Scores _____ - _____

Please Check all that apply to your baby's status immediately after birth:

☐ Torticollis ☐ Feeding Problems ☐ Displaced Joints ☐ Jaundice
☐ Respiratory Problems ☐ Broken Bones ☐ Bruising ☐ Other _____

Breastfed? ◯ ◯ YES / NO How long? _____ Formula Fed? ◯ ◯ YES / NO How long? _____

Developmental History:

Your child's spine is vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of Vertebral Subluxation (spinal nerve interference). Spinal nerve interference can affect the following: (Check any of the following milestones that your child has/had delays or difficulties meeting)

☐ Respond to stimuli ☐ Hold head up ☐ Cross Crawl ☐ Walk alone
☐ Respond to visual stimuli ☐ Sit up ☐ Stand alone ☐ Communication
☐ Reaching ☐ Other(s) _____

According to the National Safety Council, approximately 50% children fall head first from a high place during their first year of life (i.e. bed, changing table, stairs).
Did your child have a fall similar to that described above? ◯ ◯ YES / NO Explain _____

Any other traumas or injuries not described above? _____

Please list any sports your child has been involved in _____

Hobbies / interests _____

Is there anything else you would like us to know about your child? _____

I would like my child to experience the following benefits from chiropractic care:

☐ Symptomatic Relief ☐ Correction ☐ Prevention of future problems
☐ Healthier spine and nerve system ☐ Optimal health on all levels ☐ Other _____

_____ _____

Signature of Parent / Legal Guardian Date

Family Health Profile

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

	Siblings	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	☐	☐	☐

Photo and Promotional Release Consent

We love sharing pictures of the healthy children of Kauri Chiropractic! If you would allow us to take, use, and share your child's photograph and/or testimonial/comments, please sign below. For valuable consideration, I hereby irrevocably consent to and authorize the use for the purposes of marketing and promotion by Kauri Chiropractic, or anyone authorized by Kauri Chiropractic, of any and all photographs/videos which we taken of myself and my child, which may include, but are not limited to promotional materials such as social media, website, and/or print ad whatsoever, for an indefinite period of time without further compensation to me. All media shall constitute the property of Kauri Chiropractic, solely and completely. Any information voluntarily provided by a practice member shall also be used in conjunction with the above information for the purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. All other unrelated practice member information shall remain provide and protected (according to the Health Information Act).

_____ _____

Signature of Parent / Legal Guardian Date

Written Consent For A Child

Name of practice member who is a child _____

I authorize the Doctor and any and all Kauri Chiropractic Staff to perform consultation, diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my child/minor, according to their respective qualifications. As of this date, I have the legal right to select and authorize healthcare services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify Kauri Chiropractic.

_____ _____ _____

Signature of Parent/Legal Guardian Relationship Date