Burnaby Chiropractic

# Fee / Cancellation / No Show Policy

Date ____ | ____ | ____
DD MM YY

## Fee Policy

| | |
|---|---|
| Initial Consultation | $105.00 |
| Report of Findings | $80.00 |
| Regular Adjustment | $65.00 |
| Progress / Re-Examination | $80.00 |
| Progress Report + Adjustment | $75.00 |
| Re-Entry Examination + Adjustment | $100.00 |

| | |
|---|---|
| X-RAY : Full Spine | $150.00 |
| X-RAY : One Region | $80.00 |

## Cancellation / No Show Policy

Burnaby Chiropractic accepts cancellations until 24 hours of your scheduled appointment. Beyond this Burnaby 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.

## Patient Signature

Patient Signature _____

Doctor Signature _____

Burnaby Chiropractic

# Confidential Health Profile

Date ____ | ____ | ____
DD MM YY

Name of Child _____

How would they like to be addressed in our office? _____

Date of Birth ____ | ____ | ____ Gender _____ Height ____ | ____
DD MM YY FT IN

Address _____ (Please include unit number)

City _____ Postal Code _____

Email _____

Names of Parent(s) / Guardian _____

Siblings Names and Ages _____

Have they seen a Chiropractor before? ☐ Yes ☐ No Date of last check-up _____

**Referral**

How did you find out about us? ☐ Google ☐ Social Media ☐ Friend / Relative / Colleague

Who referred you? _____

**Reason For Care**

What is your primary reason for seeking chiropractic care? _____

Please mark **P** for **PAST**, or mark **C** for **Current**

| | | | | |
|---|---|---|---|---|
| ☐ Headaches | ☐ Autism | ☐ Car Accident | ☐ Stomach Upset | ☐ Poor Posture |
| ☐ ADD / ADHD | ☐ Back Pain | ☐ Behavioural Issues | ☐ Ear Infections | ☐ Frequent Fevers |
| ☐ Allergies | ☐ Bedwetting | ☐ Colic | ☐ Growing Pains | ☐ Torticollis |
| ☐ Asthma | ☐ Frequent Colds | ☐ Constipation | ☐ Speech Delay | ☐ Seizures |

☐ Other _____

Burnaby Chiropractic

# Confidential Health Profile

Date ____ | ____ | ____
DD MM YY

## Medical History

Is your child currently taking any **prescription** medication ☐ Yes ☐ No

Medication _____ Reason _____

Medication _____ Reason _____

How often is your child taking **over the counter** medication?

Medication _____ Frequency _____

Medication _____ Frequency _____

Has your child recieved antibiotics in the last 6 months ☐ Yes ☐ No

Reason _____ # of doses _____

Have you consulted with other healthcare practitioners for your concerns? ☐ Yes ☐ No

Name of Pediatrician _____

Last visit to the Pediatrician ____ | ____ | ____
DD MM YY

## Prenatal / Birth History

Length of Gestation _____ Weeks _____ Days

Where there complications during pregnancy / delivery? ☐ Yes ☐ No

If yes, please explain: _____

_____

Did you consume alcohol / cigarettes during pregnancy? ☐ Yes ☐ No

Medications taken during pregnancy (including over the counter)

Medication _____ Reason _____

Medication _____ Reason _____

Please mark the applicable birth interventions:

☐ Forceps ☐ C-Section ☐ Vacuum Extraction ☐ Epidural
☐ Induction ☐ Episiotomy ☐ Manual Traction of Neck ☐ None

Duration of Labour _____ Hours Location of Birth _____

Burnaby Chiropractic

# Confidential Health Profile

Date ____ | ____ | ____
DD MM YY

Genetic Disorders or Disabilities? ☐ Yes ☐ No

If YES, please list: _____

_____

Birth Weight _____ Birth Length _____ APGAR Scores _____ - _____

Please check all that apply to your child's status immediately after birth:

☐ Torticollis ☐ Bruising ☐ Feedings Problems ☐ Displaced Joints
☐ Broken Bones ☐ Jaundice ☐ Respiratory Problems

☐ Other _____

Is / was your child:

☐ Breastfed For how long? _____
☐ Formula fed For 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).

Check any of the following milestones that your child has / had delays or difficulties meeting

☐ Respond to Stimuli ☐ Sits Up ☐ Walks Alone ☐ Responds to Visual Stimuli
☐ Holds Head Up ☐ Reaching ☐ Stands Alone

☐ Other _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. Bed, Changing Tables, Stairs, etc.)

Has your child fallen similar to the type of falls described above? ☐ Yes ☐ No

If Yes, please explain: _____

_____

Has your child had any other traumas or injuries not described above? _____

_____

Please list any sports your child has been involved in _____

_____

Other hobbies / interests _____

Burnaby Chiropractic

# Confidential Health Profile

Date ____ | ____ | ____
DD MM YY

## Family History

Please detail any / all conditions pertaining to your immediate family members

Mother: _____

Father: _____

Children: _____

Spouse: _____

_____

## Health Goals

Please mark what activities are being restricted by your child's current health concerns

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

How would you rate your child's **current** health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Where would you like their health to be? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Do you have any specific health goals? _____

_____

## Patient Signature

Written name of **Child** _____ Date _____

Written name of **Parent / Legal Guardian** _____

Signature _____

 508 - 5050 Kingsway, Burnaby BC. V5H 4C2