Burnaby Chiropractic

# Fee / Cancellation / No Show Policy

Date ______ | ______ | ______
DD MM YY

## Fee Policy

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

| Service | Fee |
|---|---|
| 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 ______________________________

Witness Signature ______________________________

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## Confidential Intake Form

Date ______ | ______ | ______
DD MM YY

Name ____________________

How would you like to be addressed in our office? ____________________

Date of Birth ______ | ______ | ______ (DD MM YY) Gender ____________ Height ______ FT | ______ IN

Address ____________________ (Please include unit number)

City ____________ Postal Code ____________

Email ____________________

Occupation ____________ Employer ____________

Are you apart of Veteran Affairs Canada, Canadian Armed Forces or the RCMP? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouses Name ____________

Do you have children? ☐ Yes ☐ No

Childrens names and ages ____________________

Have you seen a Chiropractor before? ☐ Yes ☐ No Date of last check-up ____________

**MSP**

Are you currently utilizing / eligible for MSP? ☐ Yes ☐ No ☐ Unsure

Personal Health Number ____________________

**Insurance / ICBC / Worksafe**

Is this result of an injury or accident / ICBC Claim / Workplace accident? ☐ Yes ☐ No

Date of accident ____________________

* Burnaby Chiropractic is currently not accepting or direct billing to new ICBC claims or Workplace BC claims

**Referral**

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

Who referred you? ____________________

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Date ______ | ______ | ______
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**Reason For Care** • *What is your primary reason for seeking chiropractic care?*

______________________________

Please list your health concerns in order of severity below:

| Health Concern | Pain Intensity 0 - no pain 10 - unimaginable | Type of pain * | When did this episode start? | If you had this problem before, when? | Did the problem start with an injury? | Is the pain constant or intermittent |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

* For **TYPE OF PAIN**, please refer to this legend and use the corresponding letter(s)

**SP** - **S**pasm  **TH** - **Th**robbing  **T** - **T**ingling  **W**- **W**eakness  **N** - **N**umbness  **D** - **D**ull  **S** - **S**harp / **S**tabbing
**A** - **A**ching  **B** - **B**urning  **ST** - **S**tiffness  **R** - **R**adiating

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

What relieves your symptoms? ______________________________

What makes your symptoms worse? ______________________________

Have you seen other providers for these concerns? if so, who? ☐ Yes ☐ No ______________

Did you see any progress / results? ______________________________

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

- ☐ Headaches
- ☐ Fever
- ☐ Dizziness
- ☐ Migraines
- ☐ Poor Sleep
- ☐ Poor Balance
- ☐ Ear Aches
- ☐ Weakness
- ☐ Poor Vision
- ☐ Hearing Loss
- ☐ Frequent Colds
- ☐ Sinus Congestion
- ☐ Painful Periods
- ☐ Tinnitus
- ☐ Irregular Periods
- ☐ Urinary Trouble
- ☐ Jaw / TMJ Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Digestive Upset
- ☐ High Blood Pressure
- ☐ Elbow Pain
- ☐ Back Pain
- ☐ Groin Pain
- ☐ Change in Weight
- ☐ Wrist Pain
- ☐ Difficulty Breathing
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot Pain
- ☐ Chest Pain

☐ Other ______________________________

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Date ____ | ____ | ____
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Please mark **P** for **PAST**, or mark **C** for **Current**

- ☐ Brain Injury
- ☐ Cancer
- ☐ Stroke
- ☐ Concussion
- ☐ Diabetes
- ☐ Disability
- ☐ Heart Attack
- ☐ Scoliosis
- ☐ Tumors
- ☐ Spinal Fracture
- ☐ Spinal Injury
- ☐ Rheumatoid Arthritis
- ☐ Severe Allergies

Please list any additional serious conditions ____________________

Please list any surgical operations you've had in the last year ____________________

Please list any additional injuries, minor or major ____________________

Have you ever been in a motor vehicle accident? ☐ Yes ☐ No Date of accident __________

Have you ever been knocked unconscious? ☐ Yes ☐ No Date of incident __________

Please list ANY fractured / broken bones (current / Previous) ____________________

How would you describe your:

Quality of sleep ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Quality of diet ☐ Poor ☐ Fair ☐ Good ☐ Excellent

**Pregnancy**

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure What is your due date? __________

Do you have any pregnancy related complications? ____________________

Who is on your birth team? ☐ OBGYN ☐ Midwife ☐ Doula ☐ Other __________

**Postpartum**

When was your baby born? __________ Length of gestation __________

Were there any complications during the birthing process? ____________________

Length of labour ______ / Delivery ______ Are you currently breastfeeding? ☐ Yes ☐ No

How are you? ____________________

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## Medical History

Are you currently taking any medications? ☐ Yes ☐ No

Medication ______________________ Reason ______________________

Medication ______________________ Reason ______________________

Medication ______________________ Reason ______________________

Please list any over the counter medication: ______________________

Please list any supplements: ______________________

## Social History

Do you: ☐ Smoke ☐ Vape ☐ Tobacco ☐ Use Marijuana or Nicotine products

Amount / Frequency ______________________

Do you: ☐ Consume Alcohol

Amount / Frequency ______________________

Do you: ☐ Consume Caffeine / ☐ Coffee ☐ Tea ☐ Soft Drinks

Amount / Frequency ______________________

Are there any other chemical, physical or emotional stressors you think may be affecting you? ______________________

______________________

## Family History

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

Mother: ______________________

Father: ______________________

Children: ______________________

Spouse: ______________________

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## Health Goals

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

- [ ] Sleeping
- [ ] Family Time
- [ ] Work / Job
- [ ] Intimacy
- [ ] Driving
- [ ] Walking
- [ ] Standing
- [ ] Climbing Stairs
- [ ] Sitting
- [ ] Concentration
- [ ] Lifting Children
- [ ] Getting Dressed
- [ ] Carrying / Lifting Groceries
- [ ] Sports / Physical Activity
- [ ] Household Chores

- [ ] Other ____________________

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

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

Do you have any specific health goals? ____________________

Please check any personal health goals:

☐ Correction of complaints ☐ Prevention of future problems ☐ Optimization of overall health

## Emergency Contact

Name of emergency contact ____________________

Phone Number ____________________ Relationship ____________________

## Patient Signature

Written name ____________________ Date ____________________

Signature ____________________

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