



South Surrey Chiropractic & Wellness

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ACUPUNCTURE PATIENT INTAKE FORM

Name _____ Date _____

Date of Birth (MM/DD/YYYY) _____ Gender _____

PHN (Care Card) _____

Address _____ City _____

Province _____ Postal Code _____

Home Phone _____ Cell Phone _____

Email _____

How would you like to receive appointment reminders?

Email Text (please indicate your provider: _____)

Would you like to receive our newsletter? Yes No

Your Occupation _____ Your Work Phone _____

Work Activity Sitting Standing Manual Labor

Emergency Contact (Name) _____ Phone _____

Relationship to you _____

How did you hear about our clinic? Website Facebook Google Newspaper

Patient (Pt Name: _____) Other: _____

Do you have MSP coverage? Yes No Not Sure

Do you have Extended Health Insurance? Yes No

Extended Health Insurance Company Name: _____

Policy/Plan Number: _____ Member ID/Certificate: _____

Are you the primary coverage holder? Yes No

Primary Holder's name (if different) _____

Primary Holder's DOB (MM/DD/YYYY) _____

Primary Holder's relation to you Spouse Domestic Partner Parent

PRESENT COMPLAINT

Are you here because of a work-related injury? Yes No

If yes, please provide your WCB claim number _____

Are you here because of an auto accident? Yes No

If yes, please provide your ICBC claim number _____

What is your present complaint? Where do you feel the problem?

When did this condition/complaint start?

How did it start?

Have you had a similar condition before? Yes No

Current level of pain/ache (please circle one) 1 2 3 4 5 6 7 8 9 10 (0- no pain / 10- most pain)

How frequent is your problem? constant frequent occasional comes & goes

What activities aggravate your condition?

What relieves your condition?

On the body diagram, please indicate your areas of symptoms by drawing the appropriate symbols.

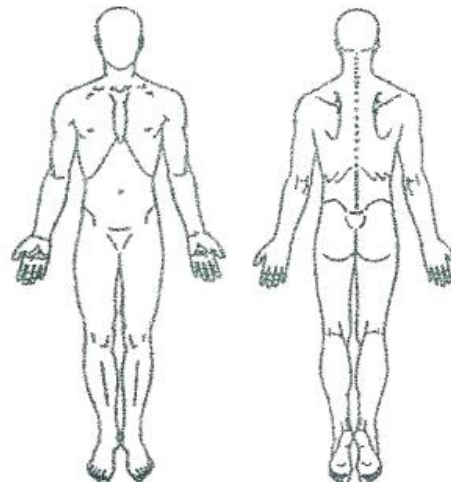
P- pain

N- numbness

W- weakness

S- shooting

A- aching



Please indicate your Bone Density:

Do you wear Orthotics? Yes No

Custom orthotics can help with your current problem, and can help prevent future problems from arising.

Would you like to discuss this with the doctor? Yes No

Are you pregnant? Yes No Number of Children:

Do you smoke? Yes No Do you consume alcohol? Yes No

Major Falls and/or accidents

Surgeries

Have you had any imaging done? X-rays MRI CT Scan Other No

WHEN and WHERE did you have this imaging done?

What body part?

Have you ever been knocked unconscious? Yes No

Hospitalizations

Please list any medications you are taking

Please list any supplements you are taking

GENERAL HEALTH

Please rate your overall stress level 1 2 3 4 5 6 7 8 9 10 (0- none / 10- extreme)

Please rate your exercise habits 1 2 3 4 5 6 7 8 9 10 (0- poor / 10- excellent)

Please rate your energy levels 1 2 3 4 5 6 7 8 9 10 (0- poor / 10- excellent)

Please rate your quality of sleep 1 2 3 4 5 6 7 8 9 10 (0- poor / 10- excellent)

Please rate your eating habits 1 2 3 4 5 6 7 8 9 10 (0- poor / 10- excellent)

General

- Insomnia Fatigue Weight loss/gain Anxiety/nervousness Mood swings
 Phobias Alcohol/drug abuse Fever Loss of sleep Tremors Allergies

Respiratory

- Chest pain Chronic cough Difficulty breathing Spitting blood Throat phlegm
 Shortness of breath Asthma Pneumonia Bronchitis Infections

Gastrointestinal

- Abdominal pain Bloating/gas Heartburn Colitis/Crohn's Constipation Hemorrhoids
 Diarrhea Gallbladder trouble Vomiting/Nausea Hernias Increased/decreased appetite

Muscle and Bone

- Joint pain Swollen joints Stiffness Muscle weakness Foot trouble Orthotics
 Arthritis Fractures Dislocation Strains/Sprains Neck pain Hip pain Leg pain

Head

- Headaches Dizziness Head trauma Fainting Light sensitivity

Skin

- Rash Itching/Hives Bruise easily Eczema Psoriasis

Urinary

- Difficulty urinating Painful urination Incontinence Frequent urination Kidney stones
 Frequent infections (UTI) Urinary urgency

Endocrine

- Diabetes Hypoglycemia Hormone Therapy Thyroid problems Excessive sweating
 Heat/cold intolerance Excessive hunger/thirst

Ear, Nose, and Throat

- Impaired hearing Ear aches/Infections Dizziness Tinnitus/Ringing Hay fever
 Nosebleeds Sinus problems Jaw/TMJ pain Corrective glasses/contacts

Cardiovascular

- High blood pressure Low blood pressure Angina Murmurs Palpitations Heart disease
 Chest pain Ankle swelling Cold feet/hands Varicose veins Pacemaker

Neurological

- Seizures/Epilepsy Strokes Tingling sensation Numbness Muscle weakness Paralysis
 Difficulty walking Poor coordination Speech problems Memory loss Head injury

Menstrual Cycle

- Cramps Heavy flow Light flow Irregular cycle Painful cycle Sore breasts
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FEE SCHEDULE

CHIROPRACTIC CARE

	Adult	Senior/Youth
Initial Visit	\$100	\$90
Subsequent Visit	\$65	\$60

DECOMPRESSION THERAPY & COLD LASER THERAPY

	Adult	Senior/Youth
Initial Visit	\$105	\$100
Subsequent Visit	\$75	\$70

SHOCKWAVE THERAPY

	Adult	Senior/Youth
Initial Visit	\$130	\$120
Subsequent Visit	\$100	\$90

CUSTOM ORTHOTICS

	Adult/Senior	Youth
1 Pair	\$480	\$350

ACUPUNCTURE CARE

Initial Visit	\$120 (60 Minutes)
Subsequent Visit	\$100 (45 Minutes)

*Adult: ages 18-64 *Senior: 65+ *Youth: ages 0-17

REGISTERED MASSAGE THERAPY (RMT)

30 Minutes	\$80
45 Minutes	\$105
60 Minutes	\$125
90 Minutes	\$180

BODYWORK

30 Minutes	\$60
45 Minutes	\$70
60 Minutes	\$80
90 Minutes	\$130

ICBC RMT

Please note that ICBC RMT initial visits will be a 60-minute appointment at no cost. Subsequent visits will be 30 minutes, also at no cost; however, patients can opt for a 45 or 60 minute subsequent RMT appointment for a small additional fee, as follows:

45 Minutes	\$15.75
60 Minutes	\$35.75

EXTENDED HEALTH BENEFITS

Direct Billing

AVAILABLE HERE!

CANCELLATION POLICY

Out of respect to your practitioner and other patients, 24 hours' notice is required for all cancellations. 100% of the appointment fee will be charged for appointments cancelled without 24 hours' notice. Our cancellation policy will be waived if you are unable to make your appointment due to an emergency or illness.

I understand and agree to the cancellation policy (please initial)

I consent to my file being shared if I decide to see another practitioner at SSCW (please initial)

I understand and agree to the above fee schedule. I understand that this fee schedule is not permanent and may change in the future without notice. Payment is due upon services rendered.

Patient Name (please print) _____

Date _____

Patient Signature (or legal guardian) _____