South Surrey Chiropractic & Wellness
#305 1656 Martin Drive, Surrey, BC, V4A6E7
T: 604-531-6446 | E: info@southsurreychiropractic.com

PRENATAL CHIROPRACTIC 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/YYY)

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

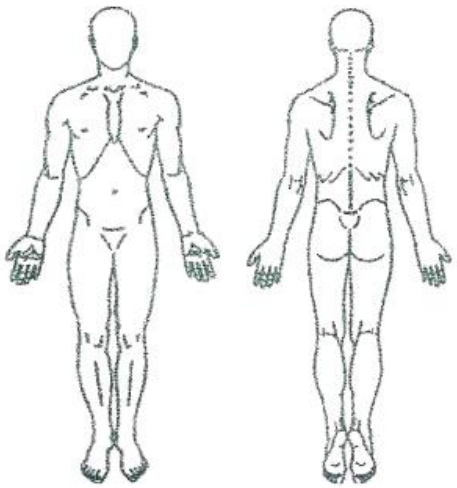
Current level of pain/ache (please circle one) 1 2 3 4 5 6 7 8 9 10 (0- no pain / 10- most pain)

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

PREGNANCY INFORMATION

How far along in your pregnancy are you?

When is your baby's due date?

Pregnancy Profile: (please check and explain any that apply to you)

□ Medications (over-the-counter or prescription)

□ Supplements

□ Care Provider Information

□ General Practitioner □ Nurse Practitioner □ Obstetrician □ Midwife

□ Doula

Please provide details:

□ Vaccinations

□ Evaluation procedures (ultrasound, amniocentesis, chorionic villus)

□ Stressful events

Is this your first pregnancy?	□ No	□ Yes
How many children do you have?		
How many previous pregnancies?		
Miscarriages?	□ No	□ Yes
How many vaginal deliveries?		
How many C-sections?		
Complications during previous deliveries?		
Induced with use of Pitocin/Oxytocin?	□ No	□ Yes
Membranes ruptured?	□ No	□ Yes
Back or hip pain during labour?	□ No	□ Yes
Was baby in a sub optimal position during labour?	□ No	□ Yes
Did you have an epidural?	□ No	□ Yes
Any operative devices used (i.e., forceps, vacuum)	□ No	□ Yes
Any postpartum complications?	□ No	□ Yes

Have you experienced any of the following in this pregnancy? (please check all that apply)

□ Headaches □ Facial paralysis □ Morning sickness □ Heartburn
□ Constipation □ Hemorrhoids □ Pre-eclampsia □ Baby breech/side lying
□ Carpal tunnel □ Pins/needles in front/side of leg □ Pain in posterior leg (sciatica)
□ Leg cramps □ Low/mid back pain □ Swelling of ankles or feet
□ Round ligament pain (pulling in front of belly) □ Gestational diabetes

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

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

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 _____