



South Surrey Chiropractic & Wellness

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REGISTERED MASSAGE THERAPY 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.

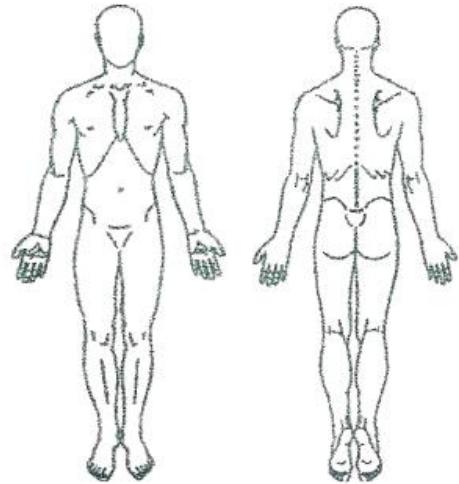
P- pain

N- numbness

W- weakness

S- shooting

A- aching



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/supplements

Please list any allergies

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)