Paradise Chiropractic Health and Wellness Center

Initial Patient Intake Form Phone: (604) 496-0626 Fax: (604) 497-0627 I info@paradisechiropractic,ca I 10116 153 Street Surrey, BC V3R 6R8

Name:	Today's Date:	
Date of Birth:	Age:	Gender: ☐M ☐ F
Address:	City, Province:	Postal Code:
BC Health Care #:	Height:	Weight:
Home Phone:	Cell Phone:	Email:
Occupation:	Employer:	Work Phone:
Marital Status:	Spouse Name:	Number of Children:
Emergency Contact:	Emergency Contact #:	Relationship:
Family Doctor:	Family Doctor #:	

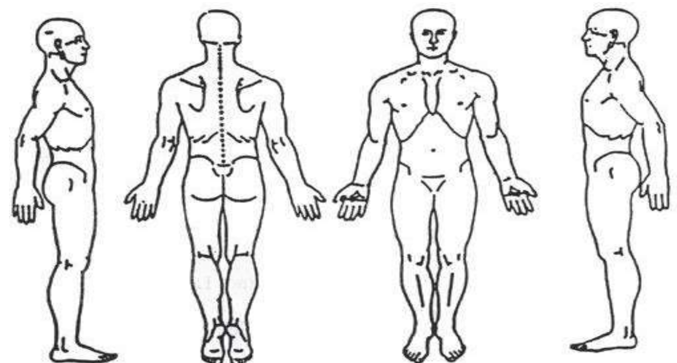
Is this an ICBC or WCB claim? ☐Yes ☐No	How did you hear about our clinic?

Reason for Appointment:

Please read carefully: Mark the areas on your body where you feel your pain. Include all affected areas. Use the appropriate symbol(s) listed below:

If your pain radiates, draw an arrow from where it STARTS to where it STOPS. Please extend the arrow as far as the pain travels.

Ache: >>>>	Numbness: ====	Pin and Needles: **0000**
Burning: **XXXX**	Stabbing: / / / /	Throbbing: ~ ~ ~ ~



Severity of Pain	
List the region of pain from most concern to least concern. Select the severity number. 0= No pain, 10= Greatest pain.	
Area #1:	Severity: ____/10
Area #2:	Severity: ____/10
Area #3:	Severity: ____/10

Medication
Do you take any medications (prescription, over the counter and/ or recreational): ☐**Yes** ☐**No**
Please list all of them and what it is intended for:

Patient Specific Functional Scale			
Is your pain aggravated by movements? ☐**Yes** ☐**No**			
Sitting: ☐	Standing: ☐	Bending: ☐	Walking: ☐
Lying Down: ☐	Turning: ☐	Coughing: ☐	Sneezing: ☐
Straining: ☐	Going down the stairs: ☐	Going Up the stairs: ☐	Others:

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Your History

____Fainting	____Rashes	____Blurred Vision	____Varicose veins	**Family History**
____Dizziness	____Easily bruise	____Eye pain	____Poor circulation	____Cancer
____Loss of Sleep	____Heart disease	____Ear infections	____Bone disease	____Stroke
____Fatigue	____Stroke	____Ringing in the ears	____Neurological disease	____Diabetes
____Nervousness	____Allergies	____Thyroid problems	____Poor appetite	____High blood pressure
____Weight loss	____Asthma	____Sinus infections	____Difficult digestion	**Women Only**
____Weight gain	____Persistent cough	____Disc herniations	____Excessive hunger	____Menstrual pain
____Headaches	____Emphysema	____Swollen Joints	____Belching or gas	____Excessive flow
____Migraines	____Rib pain	____Swelling	____Nausea	____Irregular cycles
____Palpitations	____Chest pain	____Arthritis	____Vomiting	____Menopausal symptoms
		____High blood pressure	____Constipation	____Pregnant due date:
		____Low blood pressure	If Other please specify:	

Chiropractic Fee Schedule

New Patient Visit	$130	New Patient Visit (under 18)	$80
Second Visit	$80	Subsequent Visit (under 18)	$40
Subsequent Visit	$58	MSP Premium Assistance	$35

Clinic Policies

Here at Paradise Chiropractic we understand sudden, unforeseen events can arise in everyone's lives. However, out of respect for our practitioner and patients, we ask that patients try their best not to abandon, cancel or rearrange their appointments last minute. It is our commitment to you as our patient that you have an exceptional experience here at Paradise Chiropractic and out of consideration for our practitioner and patients, we have adopted the following office policies as listed:

- **Cancellation Policy:** A **24-hour notice** is required for cancellation. Unless it is an emergency, if a patient does not show up for a scheduled appointment without 24-hour notice to the clinic, the patient will be charged the full treatment amount.

- **Clinic Financial Policy Statement:** We bill your insurance carrier as a courtesy to you. However, it is not a guarantee of payment. Benefits are determined at the time the claim is processed. You are responsible for the entire bill when the service is rendered unless prior arrangements have been made. We require that arrangements for payment or your estimated share be made at the time of service. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit it to Paradise Chiropractic.

  If you have Extended Health Care coverage, **please check with your provider to see what your company will reimburse you for your chiropractic care**. **Co-Payment, Co-Insurance and/or Deductible:** If your policy stipulates that you are responsible for making any of these payments, Paradise Chiropractic is **contractually obligated to collect these payments**. We require payments to be made at the time of service

- **Supply Policy:** Paradise Chiropractic does not bill insurance companies for supplies such as orthotics. If your doctor or chiropractor deem that it is medically necessary for you to be issued any medical equipment's or supplies, you will be required to pay for the equipment or supplies at the time that it is issued. You will be provided a receipt and a copy of your doctor's prescription for the equipment or supplies which you may then submit to your insurance company directly for reimbursement.

Thank you for your understanding and we look forward to helping you on your journey to good health.

I HAVE READ THE ABOVE, AND UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT. IF I AM A SPOUSE OR DEPENDENT, I CONFORM THAT I AM AUTHORIZED BY THE PLAN MEMBER TO EXECUTE AN ASSIGNENT OF BENEFIT PAYMENTS TO THE PROVIDER.

Insurance Company: ____________________ Policy #: ______________________ Certificate / ID #: ______________________________

Signature: ______________________________ Date: _______________________
(Patient/ Guardian/ Responsible Party)