Chemainus
Chiropractic Clinic

PATIENT INTAKE FORM

PERSONAL INFORMATION

TITLE: MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR. ☐			DATE: DD/MM/YYYY
FIRST NAME INITIAL	LAST NAME		OCCUPATION
ADDRESS	APT#	CITY	PROVINCE
POSTAL CODE	EMAIL		HOME PHONE
BIRTH DATE: DD/MM/YYYY	SEX: ☐ MALE ☐ FEMALE		CELLULAR PHONE
HOW DID YOU HEAR ABOUT THE CHEMAINUS CHIROPRACTIC CLINIC?			BUSINESS PHONE

BC HEALTH CARD # (FOR WORKSAFE AND MSP PREMIUM ASSISTANCE)

EMERGENCY CONTACT

CONTACT NAME	TELEPHONE	RELATIONSHIP

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ YES ☐ NO *IF YES, PLEASE FILL IN BELOW*

DOCTOR'S NAME	DOCTOR'S TELEPHONE	LAST VISIT
ADDRESS	CITY PROVINCE	POSTAL CODE

DO YOU HAVE ANY ALLERGIES?

CHIROPRACTIC/ACUPUNCTURE INFORMATION

WHAT BRINGS YOU IN FOR CARE TODAY?	HOW LONG HAS THIS BOTHERED YOU?

HAVE YOU SOUGHT TREATMENT ELSEWHERE FOR THIS CONDITION? *EXPLAIN TYPE AND TREATMENTS RENDERED*

HAVE YOU BEEN TO A CHIROPRACTOR/ACUPUNCTURIST IN THE PAST? *IF YES, PLEASE COMPLETE BELOW*

CHIROPRACTOR'S/ACUPUNCTURIST'S NAME	LAST VISIT
REASON(S) FOR CARE?	RESULTS : ☐ GOOD ☐ FAIR ☐ POOR

SCHEDULING

- Appointments during regular business hours must be scheduled to avoid patient wait times.
- Walk-ins are welcome, however scheduled appointments will be given priority.
- Cancellation of an appointment requires 24 hrs notice to make appointments available to other patients, failure to

PAYMENT

- Payment is expected in full each visit. Accepted forms of payment are cash, cheque, credit, & Interact.
- **WORKSAFE BC covers 100% of chiropractic fees** – PLEASE NOTIFY IMMEDIATELY if you are making a Worksafe BC claim.
- Those who qualify for MSP premium assistance will receive a $23 subsidy towards each visit, up to a total of 10 visits/year.
- Patients with third party insurance will be given a receipt they can submit to their insurance company for reimbursement.
- Should you discontinue care for whatever reason other than discharge by the doctor, any outstanding balance will become due immediately and payable in full by you.

FEES

Chiropractic		**Acupuncture**		**Registered Massage Therapy**	
Initial Consultation	$60	Initial Consultation	$80	60 minutes	$95
Subsequent Treatment	$40	Subsequent Treatment	$60	30 Minutes	$60

Please turn over…

By signing this document I hereby understand, in full, the aforementioned office policy and fee schedule.

Patient Name:_____ Date:_____

Guardian Name: _____

Patient/Guardian Signature:_____ Guardian Relationship:_____

CONSENT TO CONTACT PATIENT

Occasionally the doctor or doctors office may wish to contact you regarding a follow up or to remind you about upcoming appointments, events, or billing issues. By filling out below you are acknowledging that the doctor or office may contact you with your consent.

Is it OK to contact you at home?

Circle: PLEASE DO NOT CONTACT ME

Please contact me at:

Home: Y/N Leave Message: Y / N

Cell: Y/N Leave Message: Y / N

Bus: Y/N Leave Message: Y / N

Email: Y/N

Signature: _____