**RISE Health**
1275 Bay Street
Victoria BC V8T 1S8
PH: (250) 381-7473

# Chiropractic Intake Form

Dr Kristine Salmon

Name:_____ Sex: ☐ Male ☐ Female

Date of birth (yyyy/mm/dd)_____ Age: _____

Home #:_____ Work #:_____ Cell #: _____

Email: _____

**An email reminder will be sent the day before your scheduled appointment.*

Address:_____

City/Province:_____ Postal code: _____

BC Care Card Number: _____

Reasons for seeking treatment? _____

How did you hear about our clinic? _____

☐ Would you like to receive Practitioner Updates, New Services Announcements and Newsletters from RISE Health?

**The anti-spam legislation requires that we ask for your consent to send you emails.*

## Health Information

**Emergency Contact** Name: _____

Relationship: _____ Ph: _____

Family Doctor: _____ Sex: ☐ Male ☐ Female

Have you ever had Chiropractic Care? ☐ Yes ☐ No When: _____

Why?_____

What is your major complaint?_____

How long have you had this condition?_____ Have you had this before? ☐ Yes ☐ No

What aggravates your condition?_____

Is it getting: ☐ Better ☐ Worse ☐ Constant ☐ Comes and goes _____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

How long has it been since you felt good? _____

List surgical conditions and years: _____

Are you taking any drugs: ☐ Pain Killers ☐ Muscle Relaxants ☐ Birth Control ☐ Vitamins ☐ Other_____

_____

Are you wearing: ☐ Heel Lifts ☐ Orthodics ☐ Special supports or braces

Have you ever been in an automobile accident? ☐ Never ☐ Past Year ☐ Within 5yrs ☐ More than 5yrs

Describe:_____

Have you ever had any other personal injuries or accidents? ☐ Yes ☐ No

Describe:_____

Have you tested positive for: ☐ HIV ☐ Hepatitis-C ☐ Other_____

## Reasons for Consulting the Office

☐ I have a specific problem and only require help with this problem.
☐ After my problem has been relieved, I am interested in stratagies to insure the problem does not return.
☐ Spinal check up to improve my general health.

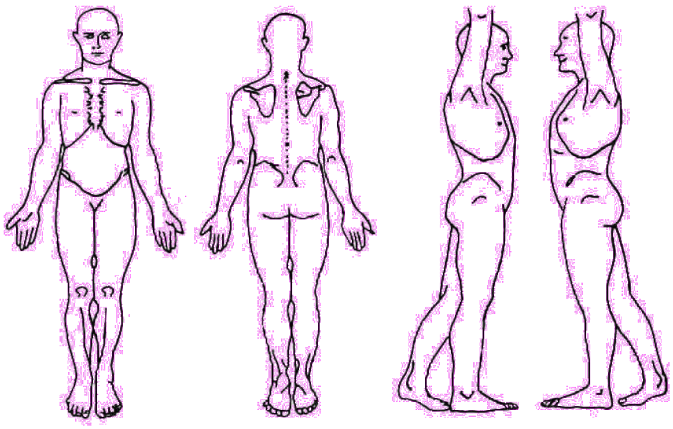
## Health History

To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem. Pain is often referred from other areas or it may be related to a more serious underlying pathology.

**Have you ever suffered from:**

| | | |
|---|---|---|
| Dizziness | ☐ Yes | ☐ No |
| Heart/ Blood Pressure trouble | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Digestive Problems | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Numbness | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| Bladder Trouble | ☐ Yes | ☐ No |
| Tingling | ☐ Yes | ☐ No |
| Kidney Trouble | ☐ Yes | ☐ No |
| Backaches | ☐ Yes | ☐ No |
| Neck Pain | ☐ Yes | ☐ No |
| Sudden weight loss | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |
| Other Medical conditions | ☐ Yes | ☐ No |

**Please mark the areas of pain on the figures below**



**On the line provided, please mark where your "Pain Status" is today.**

Absence of pain |----------| Extreme pain

Do you have or are you any of the following:

☐ Pace maker ☐ Pregnant or suspect you may be pregnant ☐ Taking Steroids

☐ Metal implants ☐ Received radio / Chemotherapy in the last 6 months ☐ Taking anticoagulants

## Family Health Information

(Past or present health problems)

Mother: _____

Father: _____

Siblings: _____

Other: _____

## Type of Coverage

☐ **MSP** ☐ **Other** _____

☐ **WCB** Claim #: _____ Adjudicator: _____

Date of Injury (yyyy/mm/dd) _____

☐ **ICBC** Claim #: _____ Adjudicator: _____

Date of Injury (yyyy/mm/dd) _____

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## Informed Consent:

I hereby consent to the performance of soft tissue therapy, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with the office or clinic personnel, the nature and purpose of chiropractic care and other procedures.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

_____ _____

**Signature** **Date**

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# Chiropractic Office Policy

Dr Kristine Salmon

## Private Paying Patients:

The fee for an Initial visits are $80.00 and Subsequent visits are $50.00.

If you are currently on premium assistance, your first treatment is $57.00 and subsequent visits are $27.00 to a maximum of 10 visits in a calendar year. Once the 10 allowed have been used the fee will go to the full price of your visit.

MSP will cover a portion of your visit for a combined total of 10 visits per calendar year (combined total refers to chiropractic, massage, and physiotherapy).

Payment must be made on the date of service. Payment can be made by Cash, Cheque, Visa, MasterCard, or debit.

If you are unable to keep your appointment, we require 24 hours notice. In the event of frequent cancellations or no show appointments we reserve the right to charge you for the missed appointments and those canceled without 24 hours notice.

## WCB – Workers Compensation Board:

Please report immediately to the staff if your visit is to be billed to WCB, so the correct forms get submitted and MSP is not incorrectly billed.

With the exception of the first visit, patients are responsible for the office fee until which time WCB has fully accepted the claim. I understand that I will be responsible for any costs not covered by WCB.

## ICBC Patients:

As there are many forms to fill out for ICBC and they are to be billed separately from MSP, please let the front desk know ahead of time that you should be billed under ICBC.
You are required to pay the fee of $57.73 for the initial visit (ICBC covers $22.27) and $32.65 per follow up visit (ICBC covers $17.35)

Patients are responsible for the full office fee until which time ICBC has approved the claim.
I understand that I will be responsible for any costs not covered by ICBC.

**I have read and understand the above office policy.**

_____ _____

**Signature** **Date**