Bedford:
1600 Bedford Hwy, Suite 102
Bedford NS, B4A 1E8
(P): 902-407-7207
(F): 902-407-7208
www.kinetesis.ca
bedford@kinetesis.ca

Personal Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth (mm/dd/yyyy): _____ Health Card #: _____

Phone Number: Home #: _____ Cell #: _____

Work #: _____ Extension #: _____

Home Address: _____ _____ _____ _____ _____
Unit# House#/Street Name City Province Postal Code

Email Address:_____

☐ **Please check this box** to consent to receiving email appointment reminders & infrequent clinic newsletters.

Occupation: _____ Employer: _____

Family Doctor Name: _____ Phone #: _____

☐ **Please check this box** if you would like us to send progress reports to your family doctor.

Emergency Contact Name: _____ Phone #: _____

Is Your Visit Today: ☐ Motor Vehicle Related ☐ Workplace Injury Related ☐ N/A

How Did You Hear About Our Clinic?

☐ Google ☐ Event: _____

☐ Facebook ☐ Doctor/Surgeon: _____

☐ Yelp ☐ Family/Friend Referral – Who Can We Thank? _____

☐ Sign/Walk In ☐ Atlantic Hockey Group – Team Name: _____

☐ O2 Wellness ☐ Other: _____

REFER A FRIEND!
Once your friend comes in for their first appointment, both names will be entered into a monthly draw to each win a **FREE 1 Hour Massage**! See the front desk for details.

Cancellation Policy

We require a **minimum of 4 hours notice** to cancel or change an appointment prior to your scheduled appointment time. Failure to give adequate notice may result in a $25 late cancellation fee or $50 no-show missed appointment fee. Please note these fees will not be covered by third party insurance.

Initials: _____

Insurance Claims

We can directly bill most Blue Cross and Green Shield plans as well as other third party insurance companies through the Telus Health network. The policy must allow for electronic billing and assignment of payment back to the clinic. We are unable to directly bill Podiatry appointments or products. Any amount not covered by insurance is to be paid for by the patient. Patients are responsible for knowing their own insurance limits and referral requirements.

Initials: _____

Payment

I understand and agree that payments for services rendered are my responsibility. I understand that my co-payment, co-insurance and deductibles are due and payable at the time of the service. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. I have read and agree to the cancellation policy and understand that I am responsible for any fees incurred due cancelling an appointment with inadequate notice or completely missing a scheduled appointment.

_____ _____

Signature of Patient **Date**

(If under 18, legal guardian must sign)

Fee Schedule

Chiropractic Services:

Initial Consultation - $100.00
Re-Examination - $80.00
Follow Up Visit - $60.00

Physiotherapy:

Initial Consultation - $95.00
Follow Up Visit - $70.00

Acupuncture:

Initial Consultation - $100.00
Follow Up Visit - $90.00
Cupping Treatment Only - $50.00

Massage Therapy:

First Visit Intro Special - 60 minutes - $65.00^{+tax}
30 minutes - $55.00^{+tax}
45 minutes - $75.00^{+tax}
60 minutes - $85.00^{+tax}
90 minutes - $115.00^{+tax}
*Cupping massages are an additional $5.00 per visit

Podiatry:

Initial Consultation - $75.00
Custom Orthotics - $350.00

KINETESIS
Spine & Joint Clinic

Acupuncture Intake Form

Name: _____ Occupation: _____ DOB: _____

Condition

What is your major complaint(s) today? _____

How long have you had this condition? _____

What types of treatment have you had for this condition? _____

Does your condition affect your sleep? Yes / No

Are you involved in any sports or physical activity? Yes / No → If yes, what? _____

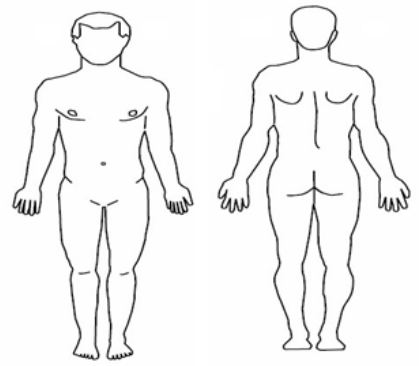
Current medications:_____

Past surgeries:_____

- Mark the area of your body where you feel the following sensation(s), using the associated symbols.

x = Pain/discomfort

o = Numbness/tingling



- Please circle the pain level that most accurately represents your pain.

0 = No pain → 10 = Unbearable pain

Average Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At Worst	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Health History - Please check if you have had any of the following:

Neuromusculoskeletal
( ) Convulsions
( ) Headaches
( ) Backache
( ) Stiff neck
( ) Pain between shoulders
( ) Spinal curvature
( ) Swollen joints
( ) Weakness
( ) Twitching
( ) Numbness
( ) Tremors

Skin or Allergies
( ) Allergies
( ) Bruise Easily
( ) Sensitive Skin
( ) Eczema
( ) Shingles

Cardiovascular
( ) Heart disease
( ) High blood pressure
( ) Low blood pressure
( ) Stroke
( ) Varicose Veins
( ) Irregular heart beat

Gastrointestinal
( ) Poor digestion
( ) Nausea/Vomiting
( ) Bloating/Gas
( ) Irritable bowel
( ) Hemorrhoids

Ear/Nose/Throat
( ) Earaches
( ) Frequent colds
( ) Sinusitis

Respiratory
( ) Chest Pain
( ) Chronic cough
( ) Difficulty breathing
( ) Wheezing

Genitourinary
( ) Bed wetting
( ) Frequent urination
( ) Painful urination
( ) Prostate trouble
( ) Inability to control urine

Women Only
( ) Pregnant
( ) Cramping /backache
( ) Miscarriage
( ) Irregular Cycle
( ) Hot flashes/menopausal

Other
( ) Diabetes
( ) Cancer
( ) Depression/Anxiety
( ) Alcoholism
( ) HIV positive
( ) Hypothyroid
( ) Hyperthyroid
( ) Cannabis Use

Do you smoke? Yes / No
If yes, packs/day _____

( ) Other not listed:
_____
_____

Informed Consent for Assessment and Treatment

I request and consent to the administering of acupuncture and other ancillary techniques as deemed appropriate by my treating therapist.

Acupuncture has been explained to me as a safe therapeutic treatment performed by the insertion of **single use, sterile, disposable needles**. The needles are inserted through the skin into the underlying muscles and tissues at specific points on the body for the purpose of alleviating mobility and re-establishing normal function.

I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I understand that there is the possibility of temporary complications that may result from acupuncture treatment, which include, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, weakness, fatigue, fainting, or aggravation of existing symptoms for a short time. I understand certain risks (but rare) of anatomical acupuncture include: infection, a stuck needle, pneumothorax. I understand that if there are any particular risks that apply to my case, my acupuncturist will discuss these with me.

I further state that the following conditions do not exist in my current state of health and that I will immediately notify my acupuncturist of any changes regarding the following:

- Pregnancy
- Pacemaker
- Local Infections
- Elevated risk of infections
- Seizure disorder (i.e. Epilepsy)
- Bleeding disorders or currently taking anti-coagulant medication

Please list if any of these conditions apply to you:

_____

I have read the above consent form. I have had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I understand that I can refuse treatment at any time.

_____ _____

Signature of Patient **Date**
(If under 18, legal guardian must sign)

_____ _____

Signature of Witness **Date**