Fall River:
890 Fall River Rd
Fall River NS, B2T 1G5
(P): 902-861-3900
(F): 902-407-7208
www.kinetesis.ca
fallriver@kinetesis.ca

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

Chiropractic New Pain / Injury Form

This form will take 5-10 minutes to complete, and are important to give you the best possible care, diagnosis & treatment plan. Thank you for your patience!

Name: _____ **DOB:** _____ **Date:** _____

What is the reason for your visit today? ☐ Pain/Injury Care ☐ Injury Prevention ☐ Optimal Health / Wellness

☐ Motor Vehicle Related ☐ Work Related

Current Pain / Injury Questions

What is your complaint(s) / Where is your pain? _____

Is this a: ☐ New Condition (first time) ☐ Flare-Up (had before) ☐ Recurrent (off/on) ☐Chronic (all the time)

When did your symptoms start? _____

How did your symptoms start? _____

Did your symptoms start: ☐ Suddenly ☐ Gradually

Are your symptoms: ☐ Improving ☐ Worsening ☐ Staying The Same | ☐ Constant ☐ Off/On

How would you describe your pain? ☐ Dull ☐ Sharp ☐ Ache ☐ Throb ☐ Burn ☐ Shooting ☐ _____

Are you experiencing any: ☐ Numbness ☐ Pins & Needles ☐ Weakness ☐ Pain w/ Cough/Sneeze

Do your symptoms stay in one spot or travel anywhere? _____

Does anything make your symptoms better? ☐ Rest ☐ Activity / Movement ☐ _____

Does anything make your symptoms worse? ☐ Rest ☐ Activity / Movement ☐ _____

Are your symptoms worse during a certain part of the day? ☐ Morning ☐ Afternoon ☐ Evening ☐ Sleeping

Have you had any treatment for this condition? ☐ Medical Doctor / Specialist ☐ Chiropractor ☐ Physiotherapy

☐ Massage ☐ Acupuncture ☐ _____

Have you had any special tests performed? ☐ None ☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Ultrasound ☐ Blood Work

What are your goals in visiting our clinic? ☐ Pain Relief ☐ Injury Rehab ☐ Injury Prevention / Maintenance

☐ Improved: ☐ Posture ☐ Flexibility ☐ Strength ☐ Movement ☐ Health

☐ _____

Do you have any questions / concerns you would like addressed? _____

_____

Pain Scale

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**

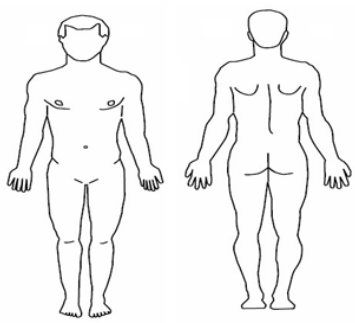
At Worst **0 1 2 3 4 5 6 7 8 9 10**

Diagram / Pain Scale

Please mark on the body diagram where you feel your symptoms using the following symbols:

X = Pain/Discomfort

O = Numbness/Tingling



Health History

Previous Injuries: _____

Previous Surgeries: _____

Current Medications: _____

Current Supplements: _____

Allergies: _____

Current Exercise / Sports: _____

Smoking: ☐ NO ☐ YES, ____ packs/day for _____ years **Alcohol**: ☐ NO ☐ YES, ____ drinks per week

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
( ) 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
( ) Allergies
( ) Cancer
( ) Diabetes
( ) Alcoholism
( ) HIV positive
( ) Hypothyroid
( ) Hyperthyroid
( ) Other not listed:
_____
_____

Mental Health
( ) Depression
( ) Anxiety
( ) Other not listed
_____
_____