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
(If under 18, legal guardian must sign)

____
Date

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

Massage Therapy Intake Form

Name: ______________________________ **Occupation:** _____________________ **DOB:** _______________

Condition

What is your major complaint(s) today? ____

How long have you had this condition? ____________________ → Have you had this condition before? Yes / No

Describe how your condition started: ____

Is the condition: ☐ Getting worse ☐ Staying the same ☐ Improving ☐ Constant ☐ Intermittent

How would you describe the pain: ☐ Aching ☐ Throbbing ☐ Sharp ☐ Shooting ☐ Burning ☐ ______________

Do you experience any: ☐ Numbness ☐ Pins & Needles ☐ Weakness ☐ Pain with Coughing or Sneezing

Is your pain worse: ☐ Morning ☐ Afternoon ☐ Evening ☐ Sleeping ☐ After Activities

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:____

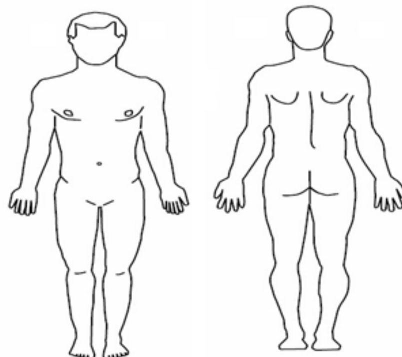
Past surgeries:____

Pain Diagram

- 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 consent to massage therapy treatments as described by the massage therapist. I also verify that the information given on this form is true and reflects my past and present health status. Should there be any change in my health I will inform my therapist before treatment.

I understand that Massage Therapists do not diagnose illness or prescribe medications, and that my treatment will be a therapeutic massage in the context of relaxation, relief of muscular tension or pain, and improving circulation.

_________________________________ ____________________

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

_________________________________ ____________________

Signature of Witness **Date**