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

Physiotherapy 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? ____

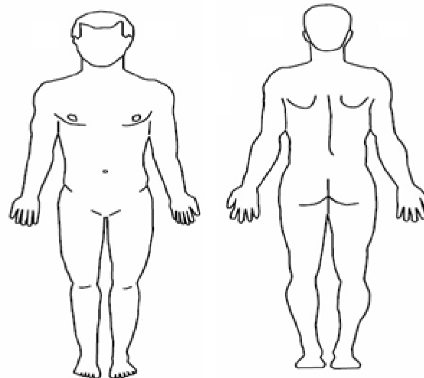
Current medications:____

Major 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 hereby give my consent to undergo physiotherapy treatment. I have had the chance to discuss with my physicians, doctors and therapists the risks and benefits of treatment for my particular condition. Where appropriate, my treatment may include manual therapy, modalities (e.g. heat, ice, whirlpool, contrast bath, wax, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, dry needling, intramuscular stimulation), and active exercise. I understand that results are not guaranteed and that I may withdraw this consent at any time. If deemed appropriate by my therapist, I agree to have a student or support personnel carry out my treatment plan under supervision.

____________________________________ ____________________

Signature of Patient **Date**

(If under 18, legal guardian must sign)

____________________________________ ____________________

Signature of Witness **Date**

: