Dr. Joanne Kostadopoulos
***Genesis Chiropractic & Wellness Centre***
255 Lacewood Drive Suite 202, Halifax, NS, B3M 4G2, (902) 445-0221 Fax (902) 445-1223



| Date : | Patient No : |
|---|---|
| | |

## *Personal History*

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: _____ Age: _____ Sex: M ☐ F ☐ *Email:* _____

Health Card: _____ Expiry Date: _____

Business/Employer: _____ Type of Work: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Circle One: Married Single Common Law Widowed Divorced Separated Other: _____

Spouse (or Significant Other): _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Who may we thank for referring you to this office? _____

**Reason for consulting our office**: **A) Improve overall wellness B) Address a specific concern C) Both**

## *Current Health Condition* *(if this does not apply to you, please skip to the next section on "Past Health History")*

**** Ensure you declare your Current Complaint/Reason for Consulting our office****

**Current Complaint(s):** _____

Have you seen other doctors for this condition? ☐ Yes ☐ No If yes, who? _____

Type of Treatment: _____ Results: _____

When did this condition begin? _____ Has the condition occurred before? ☐ Yes ☐ No

Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

What **aggravates** your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____

What **relieves** your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____

Is the condition: ☐ Getting Worse ☐ Staying Constant ☐ Coming / Going ☐ Getting Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles
☐ Constant ☐ Intermittent ☐ Burning ☐ Numb

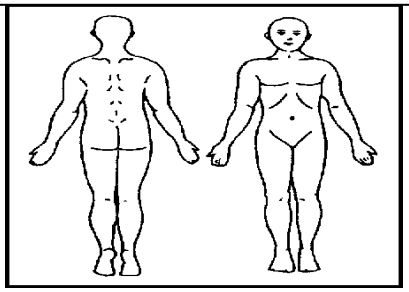
Please describe how it feels when this problem is at its worse: _____

Please circle the appropriate number which best describes the severity of your pain:

LEAST WORST

**1 2 3 4 5 6 7 8 9 10**

***Please outline on the diagram the area of your discomfort and any radiation of pain***



Please list all **medications** (Rx and OTC) you currently take and the reason for taking (dosage **not** necessary. Please use reverse side for additional medications).

1 _____ reason _____

2 _____ reason _____

3 _____ reason _____

4 _____ reason _____

Please list any **nutritional supplements/vitamins** you are taking: _____

_____

Do you suffer from any other condition than the one you are now consulting us for? _____

_____

If you do not get the problem corrected, do you think this problem will get worse in the next 5 years? ☐ **Yes** ☐ **No**

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Have you had X-rays taken in the last six months? ☐ Yes ☐ No If yes, where? _____

## *Past Health History*

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones _____ ☐ Other: _____

Previous: Childhood Traumas ☐ _____ Sports Injuries ☐ _____
Motor Vehicle Accidents ☐ _____ Work Injuries ☐ _____

Hospitalization (other than above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: _____ Approximate Date of Last Visit: _____

**Please indicate any health conditions that you have been diagnosed with:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Asthma | ☐ Allergies | ☐ Cancer | ☐ Stroke | ☐ High Blood Pressure | ☐ Heart Disease |
| ☐ Diabetes | ☐ Osteoporosis | ☐ Arthritis | ☐ Fibromyalgia | ☐ Pneumonia | ☐ Mumps |
| ☐ Influenza | ☐ Small Pox | ☐ Pleurisy | ☐ Polio | ☐ Chicken Pox | ☐ Rheumatic Fever |
| ☐ Measles | ☐ Tuberculosis | ☐ Epilepsy | ☐ Eczema | ☐ Mental Disorder | ☐ Whooping Cough |
| ☐ Anemia | ☐ Thyroid Dysfunction | | ☐ Other: _____ | | |

## *Family Health History*

***Many health problems are the result of hereditary spinal weaknesses****; this information about your family members will give us a better picture of your total health.*

Name of Family Physician: _____

Please indicate any health problems/concerns that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____

Do you have children? ☐ No ☐ Yes If yes, please list their name(s) and age(s): _____

_____

Have your children ever had a spinal check-up? ☐ No ☐ Yes If yes, where and when? _____

_____

## *Nutrition & Lifestyle*

**Rate your appetite**: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent
**Rate your diet**: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent
**Do you eat regularly**: ☐ Breakfast ☐ Lunch ☐ Dinner
**Do you eat per day**: ☐ 1 Meal ☐ 2 Meals ☐ 3 Meals ☐ 4 Meals ☐ More Than 4 Meals
**Satisfaction with diet:** ☐ Highly Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Highly Dissatisfied
**Do you consume?** ☐ Coffee ☐ Tea ☐ Alcohol ☐ Cigarettes ☐ White Sugar ☐ Water
**Do you wake rested?** ☐ Yes ☐ No
**Rate your sleep hours per night**: ☐ 4-6 ☐ 7-9 ☐ 10-12+

- Do you have a meditation, prayer, nutritional or Detox program? ☐ Yes ☐ No: _____
- If yes, please describe: _____
- When **stressed**, how do you centre yourself, or regroup? _____
- What do you consider your 3 best health habits? _____
- What do you consider your 3 worst health habits? _____
- Over the past 5 years, your health wellness and quality of life have: ☐ Decreased ☐ Stayed the Same ☐ Increased
- Why is it important for you to be healthy? _____

Dr. Joanne Kostadopoulos
***Genesis Chiropractic & Wellness Centre***
255 Lacewood Drive Suite 202, Halifax, NS, B3M 4G2, (902) 445-0221 Fax (902) 445-1223



| Date : | Patient No : |
|---|---|
| | |

**Which areas of your life are impacted or limited by your current level of health?**

☐ Work Performance ☐ Relationships ☐ Energy ☐ Recreation ☐ Travel ☐ School
☐ Focus / Concentration ☐ Exercise Routine ☐ Mood ☐ Intimacy ☐ Social Life ☐ Sleep

**Do you have a regular exercise program?** ☐ Yes ☐ No
**Lifestyle Stress Levels** ☐ High ☐ Moderate ☐ Very Little

Please indicate what **Health & Wellness Interests** you and your family have:

☐ Backaches & Sciatica ☐ Exercise & Fitness ☐ Diet & Nutrition ☐ Headaches & Neck Pain
☐ Women's Health Issues ☐ Stress Management ☐ Wellness Topics ☐ Children's Health Issues

What are the ***Health & Wellness Goals*** that you would like us to help you with? **(Please complete this section)**

☐ More energy ☐ Better sleep ☐ Freedom from pain ☐ Reduce/eliminate medication use
☐ Better concentration ☐ Deeper relaxation ☐ Enhanced emotional well being ☐ Better sports performance
☐ More balanced posture ☐ Improved digestion ☐ Overall health improvement ☐ Greater resistance to disease
☐ Easier breathing, deeper breaths ☐ Improved strength and endurance ☐ Other:_____

## Check any of the following you have had in the past six months:

### Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Stress
- ☐ Cold / Tingling Extremities

### C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Varicose Veins
- ☐ Stroke
- ☐ Ankle Swelling
- ☐ Lung Problems / Congestion

### Gastro-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

### Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Gas / Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black / Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing / Clicking Jaw
- ☐ General Stiffness

### EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

### General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

### Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Gall Bladder Problems
- ☐ Liver Problems
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Weight Trouble
- ☐ Abdominal Cramps

### Male / Female
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain / Infections
- ☐ Menstrual Cramping
- ☐ PMS
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

### Females Only
When was your last period? _____
Are you pregnant? ☐ Yes ☐ No ☐ Not Sure
Are you using contraception? ☐ Yes ☐ No

Dr. Joanne Kostadopoulos
***Genesis Chiropractic & Wellness Centre***
255 Lacewood Drive Suite 202, Halifax, NS, B3M 4G2, (902) 445-0221 Fax (902) 445-1223



| Date : | Patient No : |
|---|---|
| | |

## Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for **symptomatic relief of a condition (Relief Care).** Others are interested in having the **cause of the problem as well as the symptoms corrected and relieved (Corrective Care).** Still others want whatever is malfunctioning in **their bodies brought to the highest state of health possible with chiropractic care (Preventative Care)**. These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

**Please check the type of care desired so that we may be guided by your wishes whenever possible:**

- ☐ **Preventative Care – Life Enhancement and Wellness Care**
- ☐ **Corrective Care – Removing Cause and Remodeling Soft Tissue**
- ☐ **Relief Care – Band-Aid Care Only**
- ☐ **Check here if you want the doctor to select the type of care appropriate for your condition**.

# Informed Consent & Release of Information*(Please read carefully and sign below)*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I hereby request and consent to the performance of 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 and / or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 and sprains, rib fractures, 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 then known, is in my best interests.

I authorize the release of my information to be disclosed and re-disclosed as necessary to evaluate my need for services and to coordinate those services being provided to me to all practitioners and staff within Genesis Chiropractic & Wellness Centre as required. The purpose or need for the exchange and disclosure of this information is to: facilitate treatment, summarize treatment, coordinate continued care, enable Genesis Chiropractic & Wellness Centre and its various doctors and rractitioners to evaluate my need for services, and provide and coordinate those services to me.

**I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time. Withdrawal from consent must be validated using our 'withdrawal from consent form' which are available upon request.**

| Patient Name (Please Print) | Patient Signature | Date |
|---|---|---|
| | | |

Witness Signature

Dr. Joanne Kostadopoulos
***Genesis Chiropractic & Wellness Centre***
255 Lacewood Drive Suite 202, Halifax, NS, B3M 4G2, (902) 445-0221 Fax (902) 445-1223



| Date : | Patient No : |
|---|---|
| | |

## Office Fee Schedule and Financial Policy *(Please read and sign below)*

| ***Service:*** | ***Price:*** Child | Student | Adult | DND* |
|---|---|---|---|---|
| *Meet the Doctor*: (to determine if chiropractic will help your problem) | $0.00 | $0.00 | $0.00 | $0.00 |
| *Comprehensive New Patient Consultation & Examination*: (Includes Neurospinal & Gait Scans) | $65.00 | $75.00 | $90.00 | $90.00 |
| *Computerized Neurospinal Stress Scans*: | $30.00 | $30.00 | $30.00 | $30.00 |
| *Chiropractic Adjustment*: | $37.00 | $42.00 | $50.00 | $45.00 |
| *Re-Examination / Progress Evaluation:* | $50.00 | $55.00 | $60.00 | $54.00 |
| *Missed Visit Fee:* (if office not notified 24 Hours in advance) | $30.00 | $30.00 | $30.00 | $30.00 |
| *Returned Cheque Fee*: | $35.00 | $35.00 | $35.00 | $35.00 |

| | | |
|---|---|---|
| *Emergency Visit*: (*Adjustment*) | One Fee | $ 60 |
| *Orthotics (*with Computerized Gait & Biomechanical Foot Evaluation*)* | One Fee | $ 375 |

**DND-rate applies to Regular Force and Primary Reserve Force on Class "B" or "C" contracts only (dependants not included)*

***Additional savings are available with select payment options.***

### Orthotic Policy:

A **$175 deposit is due at the time of your orthotic fitting**. The remaining balance is due when orthotics are dispensed. A follow up appointment will be made for you two (2) weeks later. The purpose of this appointment is to ensure that you are adjusting to your orthotics and they are functioning, as they were intended. There is no additional fee for this check-up and any modifications that may be required to your orthotics are included in your initial fee. Please note: If you are unable to attend this 2 week appointment, notify the front desk immediately so an alternative time may be arranged for you. If you have not attended your follow up appointment, additional fees may apply for modifications to orthotics required outside the two (2) weeks. Custom Orthotics are non-refundable.

### Family Fee Structure:

Our centre is committed to providing the highest quality care to help you get well & stay well naturally. The care in our office is an excellent investment in your present and future well-being and is surprisingly affordable. Our office chooses to assist families wishing to benefit from chiropractic and the wellness approach in our office, by providing a family fee structure that includes special rates for students and children twelve (12) years and under. Additional savings are afforded to multiple family members who, at one time, wish to experience the many health benefits of regular chiropractic care in our office. Please speak with the Doctor or staff about our fees for care for your entire family.

### Seniors Day Program:

We offer special rates for adjustments **every Wednesday** as part of our *Seniors Day Program.* Patients over the age of sixty (60) will be honored with the rate of **$37 per adjustment on that day**.

### Motor Vehicle and Work Related Accidents:

Please note that if you have been involved in a motor vehicle accident or in an accident at work, our fee structure may differ due to the complexity of your needs in such cases. As a service to you we will, upon approval, direct bill your insurance or workers compensation board for treatment of injuries endured from the accident. Please be advised patients are personally responsible for any fee(s) assessed to their accounts for any treatment, insurance letters or reports. If for whatever reason a work related injury or motor vehicle insurance claim is not accepted or is discontinued, you are responsible for all charges levied to your account. All patients who have sustained a car accident will most likely be required, by the auto insurance company, to exhaust all personal benefits before direct billing is pursued.

### Insurance:

The purpose of most insurance policies is to support you through acute / crisis care, but not through wellness development care. Many of our practice members do receive coverage for a portion of their care and it will be our pleasure to verify your chiropractic benefits for you. **This office cannot make any guarantees about insurance reimbursement, as ultimately your contract is between you and your insurance carrier.**

*"By signing below, I acknowledge that I am financially responsible for any services rendered in this office to me or my dependents and* ***I agree to submit payment at time of services unless alternate signed financial arrangements are made."***

**Name:**_____ **Signature:**_____ **Date:**_____

**Please select form of payment for today's visit:** ☐ Visa ☐ Mastercard ☐ Cash ☐ Cheque ☐ Interac ☐ Other