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 (of your CHILD)

Child's name: ______________________________ Parent's Names: ____

Address: __________________________________ City: ______________ Province: _______ Postal Code: __________

Date of Birth:________________ Age: ________ Sex: M ☐ F ☐

Home Phone:____________________Cell Phone: __________________*Email:*_____________________________________

Emergency Contact:___________________________ Phone Number:________________ Relationship:_______________

Any Siblings____

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 "Family Health History")*

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

Has this condition occurred before? ☐ Yes ☐ No

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

What **relieves** the 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 the pain:

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

How does this problem interfere with:

The ability to enjoy family or social time? ____

The ability to enjoy hobbies or sports? ____

Any medications currently taken: ____

Any supplements currently taken: ____

Past Health History

Please indicate any health conditions your child has experienced:

☐ Asthma ☐ Allergies ☐ Headaches ☐ Dizziness ☐ Arm / Wrist pain ☐ Numbness in Limbs
☐ Tingling in Limbs ☐ Hyperactivity ☐ Shoulder pain ☐ Ringing in Ears ☐ Back / Neck pain ☐ Sleeping Problems
☐ Stomach Problems ☐ Fatigue Weight gain/loss ☐ "Growing Pains" ☐ Other ___________________________

Stress

There are 3 types of stressors: Physical, Chemical, & Emotional, that can be damaging to our nervous system.

Physical Stressors

Any traumas during pregnancy (falls, accidents) _________________

Any evidence of birth trauma: ☐ Bruises ☐ Odd Shaped Head ☐ Stuck In Birth Canal ☐ Fast or Excessively Long Birth
☐ Respiratory ☐ Depression ☐ Cord Around Neck ☐ Other: ____

Any falls from couches, beds, change tables: ____

Any traumas with bruising, cuts, stitches, fractures: ____

Any hospitalizations ____

Any surgeries or organs removed______________________________

Sports play and age began ______________________________

Number of hours a week being played ________________Weight of school backpack? ________________

Approx. hours spent at play per week ______________________________

Chemical Stressors

Was this child breast-fed? Yes ☐ No ☐ How long______________________________

Formula introduced at age ____ Type of formula used ______________________

Introduction to cow's milk at age ________________

Began solid foods at age _______ Any intolerances to food/liquids: ______________________

Vaccinations

Please indicate any vaccinations your child has had

- ☐ **DTap / Tdap** –Diptheria, tetanus, pertussis
- ☐ **Flu** - influenza
- ☐ **Hep A** –Hepatitis A
- ☐ **Hep B**- Hepititis B
- ☐ **Other** ________________________
- ☐ **Hib** –Haemophilus influenza type b
- ☐ **HPV** –Human Papillomavirus
- ☐ **IPV** – Inactivated poliovirus
- ☐ **MMR** – Measles, momps & rubella
- ☐ **MVC4** –Meningococcal conjugate
- ☐ **PCV**- Pneumococcal conjugate
- ☐ **RV** – Rotavirus gastroenteritis
- ☐ **Varicella** – Chicken pox

Did they experience any reactions to any of these?______________________________

Were you told that you had a choice in vaccinating your child? ☐ Yes ☐ No

Would you like more information on vaccines? ☐ Yes ☐ No

Emotional Stressors

Any difficulties with lactation? ☐ Yes ☐ No

Any problems with behavior? ☐ Yes ☐ No

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age when child began daycare ____

Average number of hours of television/week________

Infant Years

History of Birth

☐ Hospital ☐ Birthing Centre ☐ Home ☐ Medical ☐ Midwife

Duration of Gestation: _____ weeks

Assisted Birth: ☐ Yes ☐ No If yes (please circle): forceps, vacuum extraction, c-section, induced labour, epidural, oxytocin, prepidol, Other: ____________________

Medications delivered to mother at birth? ☐ Yes ☐ No If yes, what? ______________________

Did the mother smoke during the pregnancy? ☐ Yes ☐ No How much?_______ How long?____________

Did the mother consume alcohol during the pregnancy? ☐ Yes ☐ No How much?____________________

Growth & Development

Was the infant alert and responsive within twelve hours of delivery? ☐ Yes ☐ No

At what age did the child: Respond to sound: _______________ Follow an object: _______________

Hold head up: _____ Vocalize: _____ Walk:_____

Do sleeping patterns seem normal to you? Yes No

Adolescent Questionnaire (age 10+) *(if this does not apply to you, please skip to the next section)*

Females Only

When was your last period? _____________

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

Are you using contraception? ☐ Yes ☐ No

Family Health History

Name of Family Physician: ______________________________

Please indicate any health issues that are present in family:

Parents:______________________________

Siblings: ______________________________

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 *(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 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

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

Service	*Pricing:*	*Child*	*Student*	*Adult*
Meet the Doctor: (to determine if chiropractic will help your problem*)*		$ 0	$ 0	$ 0
Comprehensive New Patient Consultation & Examination: (Includes Neurospinal & Gait Scans)		$ 65	$ 75	$ 90
Computerized Neurospinal Stress Scans:		$ 30	$ 30	$ 30
Chiropractic Adjustment:		$ 37	$ 42	$ 50
Re-Examination / Progress Evaluation:		$ 50	$ 55	$ 60
Missed Visit Fee: (if office not notified 24 Hours in advance)		$ 30	$ 30	$ 30
Returned Cheque Fee:		$ 35	$ 35	$ 35
Emergency Visit: (*Adjustment*)			One Fee	$ 60
*Orthotics (*with Computerized Gait & Biomechanical Foot Evaluation*)*			One Fee	$ 350

Additional savings are available with select payment options.

Orthotic Policy:

A **$150 deposit is due at the time of your orthotic fitting** (when order is placed). The remaining balance is due at the time your orthotics are dispensed to you and a follow up (check up) appointment will be made for you three (3) 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 3 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 three (3) weeks.

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. 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 car accidents will most likely be required, by the car insurance company, to exhaust all personal benefits before direct billing is perused.

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