NICOLA VALLEY CHIROPRACTIC- PATIENT INTAKE FORM

Personal Information

DATE: _____

NAME_____

BC PERSONAL HEALTH CARE NUMBER_____

DATE OF BIRTH (D)_____(M)_____(YR)_____

MAILING ADDRESS _____

CITY_____ PROVINCE _____ POSTAL CODE_____

HOME NUMBER _____CELL NUMBER_____

EMAIL ADDRESS _____ WORK NUMBER_____

EMPLOYER _____OCCUPATION_____

WHO REFERRED YOU TO OUR CLINIC?_____

EMERGENCY CONTACT: _____ PHONE # _____

RELATIONSHIP: _____

HEALTH INFORMATION

WHAT IS YOUR MAIN HEALTH CONCERN?_____

HOW LONG HAVE YOU SUFFERED WITH THIS PROBLEM?_____

WHEN WAS YOUR LAST CHIROPRACTIC VISIT?_____

ARE YOU HERE FOR SHOCKWAVE THERAPY ONLY? YES ☐ NO ☐

HAVE YOU BEEN IN A MOTOR VEHICLE ACCIDENT IN BC **RECENTLY** ?_____

DATE OF ACCIDENT_____ ICBC CLAIM NUMBER_____

NAME OF ADJUSTER_____

ARE YOU HERE AS A RESULT OF AN INJURY AT WORK?_____

DATE OF INJURY_____ WCB CLAIM NUMBER_____

NAME OF ADJUDICATOR_____

NICOLA VALLEY CHIROPRACTIC
Fee Schedule

Regular Fee or Out of Province Fee: First Visit: $70.00
Subsequent Visit: $55.00

Premium & Social Assistance or Status Card Fee: First Visit: $47.00
Subsequent Visits: $32.00

Coverage under the Medical Service Plan for Chiropractic is limited to Low Income, Premium-and Social Assistance or Status Card owners in British Columbia. Each calendar year, MSP covers only a portion of your first 10 visits.

Once you have reached your MSP limit (10 visits), you are responsible for the entire cost of treatment (Private Fee).

I also authorize Dr. Colin Gage to deposit any MSP/ICBC payments received made payable to my name for services rendered.

WCB Claims:
Fees apply till Treatment Claim has been accepted by WCB. Once claim has been accepted, payment will be reimbursed and MSP visits, if applicable, will be reinstated by MSP.

By signing below I acknowledge that I have read and understood the above fee schedule. I agree to pay for all services immediately following treatment.

Signature: _____ **Date:** _____

PAYMENT IS DUE before or FOLLOWING EVERY TREATMENT

ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS
TO OPTED OUT PRACTITIONER

I authorize the Medical Service Plan to pay Dr. Colin Gage directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said practitioner.

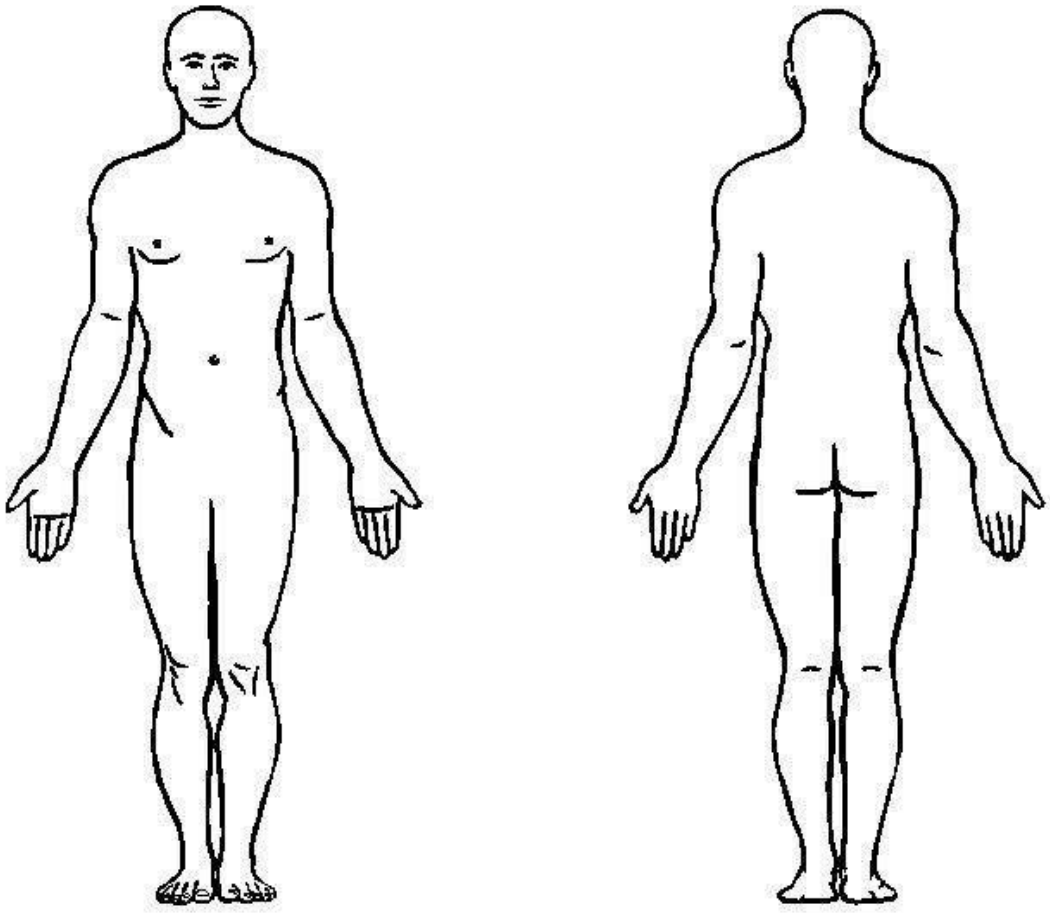
I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Service Plan which will be directed to Dr. Colin Gage to be applied against any outstanding monies I owe for services provided.

This Form allows the above named practitioner to receive you MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed
by MSP. By agreement, your practitioner may not charge you the portion reimbursable by MSP.

Signature of Patient _____ **Date** _____

Please draw the location of your pain on the body outlines, using the appropriate symbols.
Including all affected areas. **Be sure to complete the estimate for the severity of your pain by circling a number.**

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
ZZZZZ	BBBBB	XXXXX	++++++	/////
ZZZZZ	BBBBB	XXXXX	++++++	/////



Right Side **Front** **Left Side** **Left Side** **Back** **Right side**

NO PAIN 1____2____3____4____5____6____7____8____9____10____INTOLERABLE PAIN

Please check any problems that you are presently having or have had in the past:

General Symptoms
____Headaches
____Fever
____Chills/Sweating
____Fainting
____Dizziness
____Loss of Sleep
____Nervousness
____Weight Loss
____Numbness or pain
In arms, hands, or legs
____Allergies
____Asthma
____Ear Aches

Respiratory
____Coughing
____Chest Pain
____Difficult breathing

Muscle & Joints
____Stiff Neck
____Swollen Joints
____Foot Trouble
____Shoulder Pain
____Elbow/Wrist Pain
____Hip/Knee Pain
____Arthritis

____Painful Menstruation
____Excessive Flow
____Irregular Cycle
____Cramps
____Backache
____Pregnancies
____Children

Genitourinary
____Trouble Urinating
____Kidney Infection

Family History (ie diabetes, heart, stroke, cancer):

____Smoke
____Alcohol
____Medications: _____

_____

Name: _____ Date _____