



Sundance Chiropractic & Wellness

47 Sunmills Dr. S.E.

Calgary, AB T2X 2G6

Off: 403-873-2077 / Fax: 403-873-2076

www.sundancechiro.com

CANCELLATION AND FEE POLICY

Chiropractic

Initial Exam/Treatment	\$85
Chiropractic Office Visit	\$50
Shockwave (+\$25 each additional body part treated)	\$125

Therapeutic Massage

30 min. Massage	\$65
45 min. Massage	\$80
60 min. Massage	\$95
90 min. Massage	\$130

Physiotherapy

Initial Exam/Treatment	\$100
Physiotherapy Office Visit	\$75
Shockwave (+\$25 each additional body part treated)	\$125

All prices above include GST if applicable.

This is the current fee schedule for services available at Sundance Chiropractic & Wellness, and may change from time to time with notice. Discounted prices may be available for seniors and students. Please inquire at the reception desk for details regarding other goods or services.

Please note we can direct-bill some insurance companies as well as WCB on behalf of our clients. This is a *courtesy* service, and may not be available for some insurance companies and/or some services. Please consult your human resources manager for the specific details regarding your plan.

Please note that the client is always responsible for his or her own account for all services rendered in the event that the insurance company or WCB refuses some or all of the reimbursement.

It is the policy of Sundance Chiropractic & Wellness to charge full fees for missed appointments or for canceling any scheduled appointments with less than 24 hours notice.

Dated this _____ day of _____, 20_____

Patient Name (please print) _____

Signature _____

Witness _____



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment **FORM L**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)

WELCOME TO
Sundance Chiropractic & Wellness

Name: _____ Sex: M F Date: _____

Address: _____ Postal Code: _____

Email Address: _____ (email reminders)

Telephone (Home): _____ (Office): _____ (Cell): _____

Emergency Contact: (name) _____ (phone number) _____

Occupation: _____

Marital Status: Single Married Divorced

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Are you a full-time post-secondary student or over 65 years of age? Yes No

School attending? _____ Student ID # _____

How did you find out about us?: _____

Name of Physician referring? _____

CLIENT HEALTH INFORMATION

Present Area of concern: _____

When did this condition begin? _____ Is this a Work Injury? _____

Have you had any previous treatment for this condition? _____

What type of care you desire: Temporary Relief Corrective Care Preventive or Wellness Care

Have you been treated for any health conditions in the last year? Yes No

If yes, please explain: _____

Name of your family physician: _____

Names of specialists currently consulting: _____

List all medications you are presently taking: _____

Please() check any of these professionals you have seen and the **date of visit**.

Chiropractor _____ Naturopath _____

Massage Therapist _____ Acupuncturist _____

Cranio-Sacral Therapist _____ Midwife _____

Dr. Chinese Medicine _____ Other _____

List all Major Surgeries or Operations and when they occurred: Appendix: _____

Tonsils: _____ Gall Bladder: _____ Hernia: _____

Heart: _____ Back or Neck: _____ Other: _____

List Major Accident or Falls: _____

Please Check () any conditions which are **presently** causing you a problem.
Please **underline** any that have bothered you in the **past**.

General

- Enlarged Glands
- Loss of weight
- Hypoglycemia
- Nervousness
- Vision problems
- Hearing problems
- Frequent colds or flu
- Hyperthyroid
- Gas/bloating
- Constipation
- Diarrhea
- Colitis
- Black/bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder trouble
- Eczema
- Psoriasis
- Varicose veins
- Asthma
- Shortness of breath
- Heart problems

Body systems

- Frequent urination
- Painful urination
- Blood in urine
- Kidney stones
- Prostate problems
- Anemia

Musculoskeletal

- Low back pain
- Neck pain
- Arm pain
- Shoulder pain
- Elbow pain
- Wrist pain
- Leg pain
- Knee pain
- Foot pain
- Pain/numbness down arms or legs
- Painful tailbone
- Pain between shoulders
- Scoliosis
- Arthritis
- Difficulty chewing
- Clicking jaw
- Ankle swelling
- Orthopedic problems

Nervous System

- Vertigo
- Loss of feeling
- Dizziness
- Fainting
- Headaches
- Ringing in ears
- Confusion
- Depression

Check any of the following you have experienced:

- Alcoholism
- Venereal infection
- Epilepsy
- Stroke
- Other _____
- Arthritis
- Hypoglycemia
- Tuberculosis
- Rheumatic fever
- Diabetes
- Cancer
- Allergies
- Heart disease
- High Blood pressure
- Osteoporosis

Has anyone in your family had any of the following?

- Heart disease
- Cancer
- Other _____
- High blood pressure
- Stroke
- Arthritis
- Diabetes

Please rate your current level of/or consumption of the following:

	None	Light	Moderate	Heavy	Details
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please note that **fees are due as services are rendered**, unless specifically arranged with your health care practitioner. I acknowledge that I am responsible for my account payments upon each visit by Cash, Cheque, Debit, Visa or MasterCard.

NAME _____ **DATE** _____