



***Vitality***  
Chiropractic & Laser Therapy Clinic

Dr. Dee Anne Nadeau • Dr. Brodie Nadeau  
205 Victoria Street • Nelson BC • V1L 4K2  
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### Initial Consultation Form

Name: \_\_\_\_\_ Initial Visit Date: \_\_\_\_\_

DOB (M/D/Y): \_\_\_\_\_ Care Card #: \_\_\_\_\_

Address: \_\_\_\_\_ City/Prov: \_\_\_\_\_

Postal Code: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone #'s H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

Occupation: \_\_\_\_\_ Benefit Provider(s): \_\_\_\_\_

Is your visit today related to an ACTIVE workplace or motor vehicle injury?  Yes  No

Who may we thank for referring you? \_\_\_\_\_

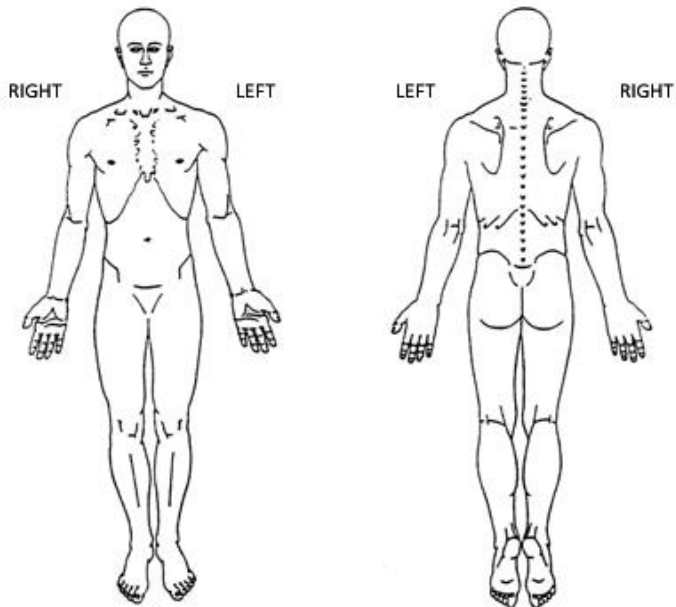
**As each patient's needs and goals are unique, so is our approach to patient management and treatment plan design. Which statement best describes the reason you sought the help of our chiropractors?**

- Diagnose my problem and help me through the initial steps of my recovery.
- Assist me in getting to the point I can return to my work/activity/sport in some fashion.
- Support and guide me all the way to a complete and robust recovery.
- Work with me on an ongoing basis in the pursuit of optimal wellness and injury prevention.

FRONT

BACK

Please indicate any painful or problem spots on the diagram with an 'X'



Primary **COMPLAINT**: \_\_\_\_\_

How **LONG** have you had this problem? \_\_\_\_\_

How did it **START**? \_\_\_\_\_

Have you experienced this problem **BEFORE**? \_\_\_\_\_

What **AGGRAVATES** your condition? \_\_\_\_\_

What **RELIEVES** your condition? \_\_\_\_\_

Does your pain **TRAVEL** to other parts of your body? \_\_\_\_\_

Is the pain **CONSTANT**?  Yes  No    How **INTENSE** is it at its worst? \_\_\_/10    Is it **TRENDING**:  Better  Worse  Same

Does your condition negatively **IMPACT** your:     Work     Sleep     Sports     Daily Tasks     Mood     Relationships

What **OTHER** health professionals have you seen for this condition? \_\_\_\_\_

What **TREATMENT** did you receive? \_\_\_\_\_ Was the treatment **HELPFUL**?  Yes  No

Have you ever had any prior **CHIROPRACTIC** experience?  Yes  No    Was this treatment **HELPFUL**?  Yes  No  Somewhat

If you have had previous chiropractic experience please describe the **TECHNIQUES** you are familiar with and whether they were helpful (i.e. manual vs. instrument adjustments, ART, Graston, etc.) \_\_\_\_\_

Do you currently experience any of the following **NEUROLOGICAL** symptoms? Please check all which apply:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dizziness/vertigo   | <input type="checkbox"/> Double vision              | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Difficulty swallowing      | <input type="checkbox"/> Difficulty walking    |
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Lack of sensation/numbness | <input type="checkbox"/> Confusion             |

Explain any of the checked items: \_\_\_\_\_

List **PREVIOUS** surgeries/accidents/major injuries: \_\_\_\_\_

List current **MEDICATIONS**: \_\_\_\_\_

List your regular physical **EXERCISE**: \_\_\_\_\_

Are there any other **HEALTH** conditions, concerns, or diseases the chiropractor should be aware of (including pregnancy)? \_\_\_\_\_

**DOCTOR'S NOTES:**

## Office Fees & Policies

Private chiropractic fees are as follows with payment due prior to treatment:

**Initial visit (chiropractic or laser)** - \$70.00 Reg / \$50.00 MSP

**Subsequent chiropractic visits:**

**15 min.** - \$45.00 Reg / \$22.00 MSP

**20 min.** - \$55.00 Reg / \$32.00 MSP

**25 min.** - \$65.00 Reg / \$42.00 MSP

**30 min.** - \$75.00 Reg / \$52.00 MSP

**Subsequent laser visits:**

**30 min. Laser** - \$55.00 Reg / \$32.00 MSP

**45 min. Laser** - \$60.00 Reg / \$37.00 MSP

**60 min. Laser** - \$80.00 Reg / \$57.00 MSP

*\*For a full fee schedule including combined chiropractic/laser treatments and programs please inquire with reception*

**24 hr notice** is required for cancellation of appointments

Fees for missed appointments without 24 hrs notice

- **\$25.00** for the first missed appointment /
- **FULL CHARGE** for all future missed appointments

[  ] Please initial indicating you have read and agreed to the above policies

## Medical Services Plan (MSP) Benefits

If you have **MSP Premium Assistance** coverage which is being subsidized by the government, it will cover the partial payment of a combined total of 10 visits per year of chiropractic, physiotherapy, massage therapy, acupuncture, naturopathy, and podiatry. Please sign below if BC Medical is paying all or a portion of your monthly BC care card fees. This will allow us to apply any of your eligible MSP subsidy against the cost of the chiropractic visit.

I request that benefits payable to me under the Medical and Health Care Services Act for chiropractic care rendered by Dr. Dee Anne Nadeau and/or Dr. Brodie Nadeau will be assigned to them and direct that they may be applied, as received, against the outstanding balance of monies owing by me to Dr. Dee Anne Nadeau and/or Dr. Brodie Nadeau for care provided. I understand that once my subsidized MSP partial payments have been exhausted I am responsible for the total cost of the chiropractic visit. I am responsible for payment of the difference between the subsidized fee and the total visit cost whatever that may be.

Signature:

Date:

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Vitality Nelson Chiro Corporation



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Dear Patient,

Canada's e-communications laws dictate that organizations are required to obtain consent before sending commercial electronic communications. Both emails and text messages are subject to this legislation.

At Vitality we use email and/or text appointment reminders delivered in advance of your appointment. We offer this as a courtesy to help ensure we have booked your appointment correctly as well as to reduce the incidence of missed and forgotten appointments (please note our cancellation/no-show policy). However you are still responsible for keeping track of your own appointment in the event a reminder does not successfully make it to you.

**Please know we will not contact you with any other unsolicited electronic communications.** Nonetheless, you do retain the option of not receiving electronic reminders altogether.

Please check the box of the appropriate statement(s) below:

- I wish to receive **Email Appointment Reminders** at this email address:  
\_\_\_\_\_  
*\*please add health@vitalitynelson.com to your contacts to bi-pass spam filters*
- I wish to receive **Text Appointment Reminders** at this cell phone number:  
\_\_\_\_\_ with my mobile carrier: \_\_\_\_\_
- I have read the cancellation/no-show policy and I do not wish to receive any electronic appointment reminders

Your consent will remain valid until you wish to remove it. Please inform the reception staff if this is the case and they will amend this form accordingly.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient (Guardian) Signature

\_\_\_\_\_  
Date

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