



## HEALTH HISTORY

**SYMPTOMS:** (Please circle any symptoms that you have experienced within the past 6 months)

Headaches	Pins & needles in legs	Loss of smell
Neck pain	Pins & needles in arms	Loss of taste
Sleeping problems	Shortness of breath	Nausea
Back pain	Fatigue	Feet cold
Nervousness	Depression	Cold Sweats
Irritability	Light bothers eyes	Chest pains
Dizziness	Fainting	Ears ring
Blurred vision	Gas, bloating, indigestion	Loss of memory
Loss of balance	Upset stomach	

## LIFESTYLE & STRESSORS:

Any experience that overwhelms your physical, emotional, nutritional and/or chemical balance may cause vertebral Subluxation/ Nervous system Interference. Help us understand your accumulative health status by **check mark** the appropriate below

### PHYSICAL

<input type="checkbox"/> Injuries	<input type="checkbox"/> Surgery	<input type="checkbox"/> I was a Caesarean birth
<input type="checkbox"/> I was active as a child	<input type="checkbox"/> Poor posture	<input type="checkbox"/> I feel flexible
<input type="checkbox"/> Physical stress	<input type="checkbox"/> Work injuries	<input type="checkbox"/> Muscle aches frequently
<input type="checkbox"/> I do regular stretching	<input type="checkbox"/> Repetitive tasks at work	
<input type="checkbox"/> I exercise	<input type="checkbox"/> I do strength training	
<input type="checkbox"/> Family history of disease(s) _____		

### EMOTIONAL

<input type="checkbox"/> Single parent family	<input type="checkbox"/> Abused	<input type="checkbox"/> Moved a lot
<input type="checkbox"/> Stressful job	<input type="checkbox"/> Mental stress	<input type="checkbox"/> English is second language
<input type="checkbox"/> Frequent travel	<input type="checkbox"/> Take vacations	<input type="checkbox"/> Awaken rested
<input type="checkbox"/> Periods of depression		

### NUTRITIONAL

<input type="checkbox"/> Irregular eating habits	<input type="checkbox"/> Balanced diet	<input type="checkbox"/> Alcohol use
<input type="checkbox"/> Food cravings	<input type="checkbox"/> Caffeine	<input type="checkbox"/> 8–10 glasses of water a day
<input type="checkbox"/> Supplements _____		

### CHEMICAL

<input type="checkbox"/> I smoke	<input type="checkbox"/> Parents smoke	<input type="checkbox"/> Vaccinations
<input type="checkbox"/> I work with chemicals	<input type="checkbox"/> I have allergies	<input type="checkbox"/> Many courses of antibiotics
<input type="checkbox"/> Prescription medications _____		

If there is any other information regarding your health status that you think would help us, please mention below:

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I believe my commitment to health is:

NOT IMPORTANT 1    2    3    4    5    6    7    8    9    10    UTMOST IMPORTANCE

**SYMPTOMS OF PRESENT CONDITION(S):**

Mark the area(s) on the diagram where you feel the described sensations.

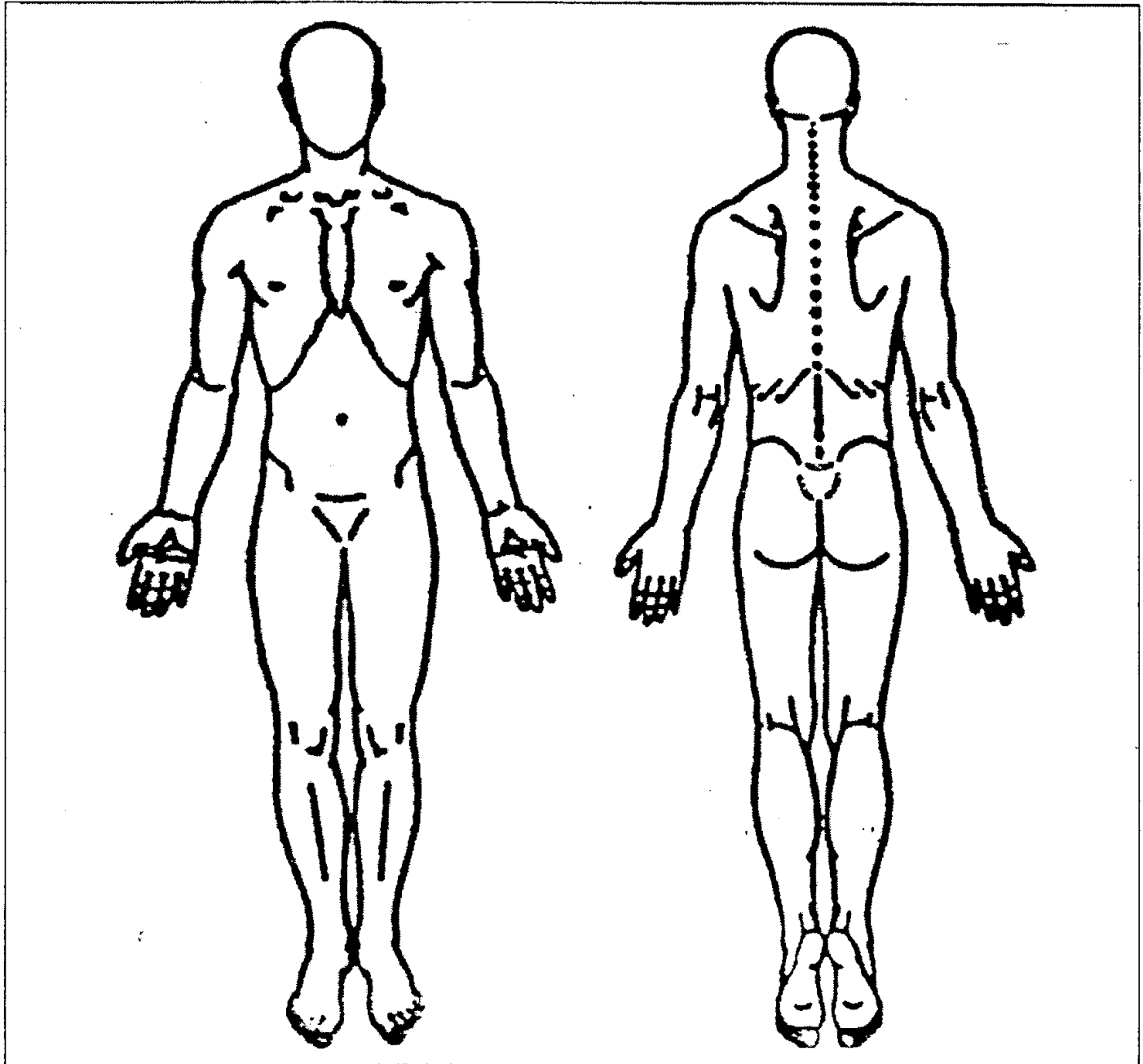
Please include all affected areas including regions of radiating pain, numbness and tingling.

Please use the following symbols:

**XXXXX** – sharp pain

**OOOO** – dull, aching

**///////** - numbness or pins & needles



## Fee Policy

Welcome to the office of Coco Chiropractic Wellness! The following is an outline of the financial policies of the office.

### FEES:

#### **ADULT**

- Initial Consultation, Examination & Adjustment \$75
- Subsequent Visits \$50
- Progressive Exam & Re-exam \$60

#### **CHILD (up to 12 years old)**

- Initial Consultation and Exam \$60
- Subsequent for all children \$45

### **Medical Services Plan of British Columbia**

- If under Premium Assistance, you may be eligible to receive \$23 for 10 visits each of one or a combination of the above services. You pay the private fee and are responsible for reimbursement.
- Please notify the front desk if you are receiving Premium Assistance so that we may submit your claim to MSP on your behalf.

### **Extended Health Care Benefits**

- It is important to check with your plan administrator if you are entitled to reimbursement. Plans may reimburse up to 100% of your fee.
- We do not bill plans directly. You must pay the fees as listed above and submit a receipt or summary to your insurance company for reimbursement.

### **Insurance Corporation of British Columbia**

- Partial insurance coverage may be provided for injuries resulting from motor vehicle accidents. Prior to billing ICBC we require a valid claim number, adjustor's name, contact number and ICBC approval.
- In addition to the insurance portion, your private portion of the fees are itemized below, these may be submitted to your adjustor or extended medical:
  - Initial Consultation & Examination \$45
  - Subsequent Visits \$30
  - Re-exam: Regular client with new injury \$35
  - Progressive Exam \$35

The client is responsible for any insurance portion of the charges ICBC refuses to cover in addition to the fees above.

### **Missed Appointments**

- Visit fee charges still apply for any appointments cancelled or missed without 24 hours notice. We have a 24 hour/ 7 days a week voice mail and e-mail for your convenience.

**I have read and understand these policies.**

X \_\_\_\_\_  
Signature