

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

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

EMOTIONAL

_____ Single parent family	_____ Abused	_____ Moved a lot
_____ Stressful job	_____ Mental stress	_____ English is second language
_____ Frequent travel	_____ Take vacations	_____ Awaken rested
_____ Periods of depression		

NUTRITIONAL

_____ Irregular eating habits	_____ Balanced diet	_____ Alcohol use
_____ Food cravings	_____ Caffeine	_____ 8–10 glasses of water a day
_____ Supplements _____		

CHEMICAL

_____ I smoke	_____ Parents smoke	_____ Vaccinations
_____ I work with chemicals	_____ I have allergies	_____ Many courses of antibiotics
_____ Prescription medications (please list): _____		

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

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):

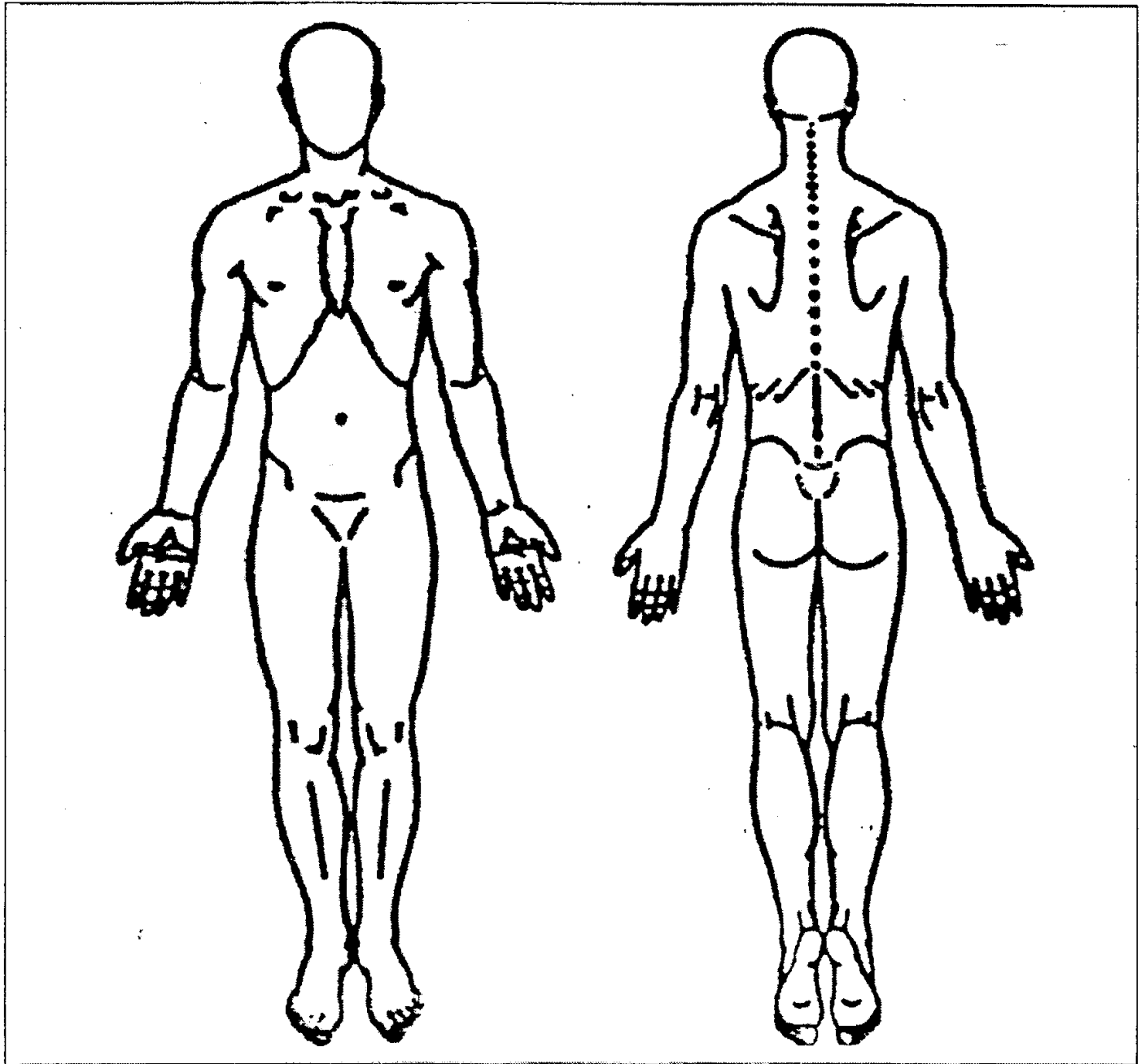
Mark the area(s) on the diagram where you feel the described sensations. Please include all of the affected areas including regions of radiating pain, numbness and tingling.

Please use the following symbols:

XXXXX – sharp pain

O O O O – dull, aching

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



BONN CHIROPRACTIC

Fee Policy

Welcome to the office of Bonn 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 \$50
 - Subsequent Visits \$35
 - Re-exam: Regular client with new injury \$40
 - Progressive Exam \$40

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