BONN CHIROPRACTIC

Dr. Stephanie Bonn

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you.

NAME:_____ Birth date: ____/____/____ Date:_____
D M Y

Address:_____ City:_____ Prov:_____ Postal Code:_____

Home #: (_____)_____ Cell #: (_____)_____ Work #: (_____)_____

Would you like to receive text reminders? **YES / NO** If so, **please provide cell number above and plan provider**.
If **no**, you will receive a reminder via email. **PROVIDER:** _____ (ie. Rogers, Telus, etc)

Email address:_____ *office records only

Occupation:_____ Employer:_____

Who may we thank for referring you? _____

Emergency contact: _____ Relation: _____ Ph #:(_____)_____

Number of children and ages: _____

Medical Doctor:_____ Ph #:(_____)_____ Date of last physical:_____

Have you ever received Chiropractic care? **YES / NO** Date of last adjustment:_____

Personal Health Number (Care Card):_____

DO YOU HAVE: **EXTENDED HEALTH CARE COVERAGE?** YES / NO **or** **MSP PREMIUM ASSISTANCE?** YES / NO

We want to provide you with the best possible health care. To do this, we will first need to understand what you want. Please mark the one that most closely reflects your health care objectives:

_____ **WELLNESS** – I want to build my inner strength. I am conscious about my heath, diet, and exercise, and actively pursue these because I feel better, perform better and it maximizes my potential.

_____ **TREATMENT ONLY** – I only consult a health practitioner when I have an ache or pain and discontinue care when it has cleared up.

Motor Vehicle accident(s):_____ICBC Claim#:_____
Workplace Injuries:_____WCB Claim#:_____
Other injuries:_____

MAJOR COMPLAINT:_____

This condition interferes with: work:____sleep:____routine:____other (please specify):_____

HEALTH HISTORY

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

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

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

EMOTIONAL

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

NUTRITIONAL

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

CHEMICAL

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

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:

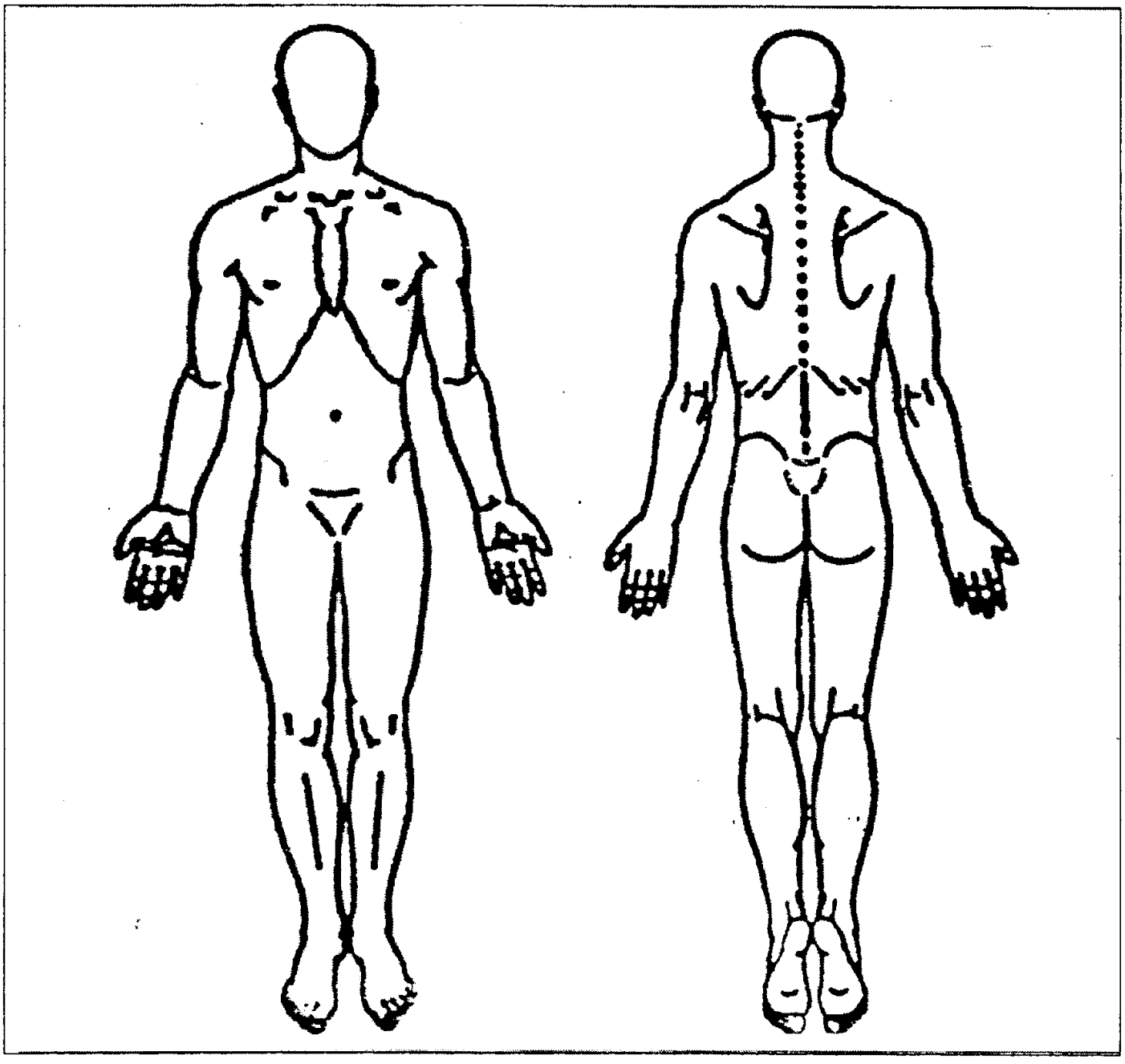
NOT IMPORTANT 1 2 3 4 5 6 7 8 9 10 UTMOST IMPORTANCE

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 **OOOO** – 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