DRS. BRIMMELL/RUSSAK/MORGAN/STEFANATO **SUPERIOR CHIROPRACTIC**
570 Red River Rd., Thunder Bay, ON, P7B 1H3
Ph: (807) 345-6700 Fax: (807) 345-6717

PATIENT INFORMATION

____
FIRST NAME LAST NAME MALE / FEMALE

____
ADDRESS CITY PROVINCE POSTAL CODE

DATE OF BIRTH (DD/MM/YY)______/_______/______ SIN (IF WSIB) _________________________

HOME # ___________________ CELL # _______________________ WORK # ___________________

EMERGENCY CONTACT# ___________________ EMAIL ADDRESS _________________________

WOULD YOU LIKE EMAIL REMINDERS FOR SCHEDULED APPOINTMENT? YES NO

CONSENT FOR CLINIC TO SEND EMAILS YES NO

HAVE YOU EVER SEEN A CHIROPRACTOR? YES NO LAST VISIT _______________________

IF YES, WHAT DID YOU LIKE/DISLIKE ABOUT TREATMENT _____________________________

MEDICAL DOCTOR ______________________________

NAME OF PERSON THAT REFERRED YOU ____

IS THIS PROBLEM RELATED TO A MOTOR VEHICLE ACCIDENT? YES NO

IS THIS PROBLEM RELATED TO AN INJURY AT WORK? YES NO

DO YOU HAVE EXTENDED HEALTH BENEFITS? YES NO

PRIMARY PLAN ____

POLICY #_____________________________________ ID# __________________________________

POLICY MEMBER NAME _____________________________________ DOB: __________________

SECONDARY PLAN ____

POLICY# ______________________________________ ID# __________________________________

POLICY MEMBER NAME _____________________________________ DOB: ___________________

HEALTH STATUS

Primary complaints____

How did you develop the problem? Please check one.

an event (accident/injury) _____ OR a process (over time/repetitive strain)? _____ OR unknown _____

Explain: ____

What is your objective in coming to our clinic today? _______________________________

DAILY HABITS/LIFESTYLE

Do you exercise regularly? YES NO If yes, please describe _________________________

Do your daily work habits include? LIGHT LABOUR HEAVY LABOUR COMPUTER WORK

Name of Employer ________________________ Occupation Title ______________________

General description of your diet (Be honest!)____

Food Sensitivities? _____________________________ Food Allergies? ___________________

Environmental Sensitivities/Allergies? (i.e. Scents, Pollen) ___________________________

Vitamin/Mineral/Herb Supplementation____

Hobbies/Activities____

Do you see a massage therapist? YES NO Do you see an acupuncturist? YES NO

Tobacco use? YES NO Caffeine use? YES NO Alcohol use? YES NO

Current medications____

High Stress? YES NO If yes, reason____

Women – Are you pregnant? YES NO If yes, due date____________________________

Please list any injuries and/or surgeries you have had: _____________________________

FEE SCHEDULE

Initial Examination	$100.00	Adjustment	$45.00	Over One Year	$54.00

I understand that I am responsible for paying for my chiropractic care. This office may bill my extended health plan or WSIB for the part of my account that is covered by them and I agree to pay any and all amounts that are not paid by third party billing.

DATE_________________ PATIENT SIGNATURE ___________________________________