Dr. S.BRIMMELL, D.C./DR. D.MORGAN, D.C. **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

HOME # _____ CELL # _____ WORK # _____

EMAIL ADDRESS _____

WOULD YOU LIKE EMAIL REMINDERS FOR SCHEDULED APPOINTMENT? YES NO

CONSENT FOR CLINIC TO SEND EMAILS ? YES NO

DATE OF BIRTH (DD/MM/YY)_____/_____/_____ SIN (IF WSIB) _____

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 OTHER_____

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/Herbs _____ Brand? _____

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 $40.00 Over One Year $50.00

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 _____