WELCOME TO OUR OFFICE
OUTLINE OF PROCEDURES FOR NEW PATIENTS:

Step 1:

Confidential Patient Health Record: All new patients are requested to thoroughly complete the following pages.

Step 2:

Consultation & Examination: You will receive a **Comprehensive Consultation and Examination** with Dr. Berenstein to discuss your health problems and to determine if chiropractic care is appropriate for your condition. The examination is an in-depth, advanced assessment of your musculoskeletal and nervous systems. This assessment will incorporate the following testing: **Postural Analysis, Range of Motion, Muscle Testing, Nerve Testing, Gait Analysis, Functional Movement Assessment, and Spinal and Extremity Joint Assessment.**

Step 3:

Report of Findings: Following your examination, Dr. Berenstein will inform you of your examination results and recommend a treatment plan. As well, if indicated, appropriate referrals will be made for further medical or x-ray investigation or to other allied health professionals for co-management of your condition.

Step 4:

Treatment: Your treatment plan will begin after your Report of Findings and continue as scheduled until your condition has been fully corrected, or until **maximum possible improvement has been obtained.** Treatment plans will often incorporate some or all of the following therapies: **Chiropractic, Manual Therapy, Laser Therapy, Exercise Rehabilitation, and Custom Orthotics.**

To save time and allow us to better serve you, please complete all questions on the next 3 pages.
Thank you!

Personal & Contact Information

Name: _____

Date of birth: _____ (month / day / year) Age: _____ Gender: _____

Address: _____

City: _____ Province: _____ Postal Code:_____

Tel: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Email Address*: _____

Why do I need your email? Email provides me a convenient method to communicate with you about your health and treatment. And, as an extension of the care you receive in our office I would like to add you as a subscriber to my website to help you* ***Get Well, and Stay Well.*

Type of Work / Occupation? _____

Circle One: married single widowed divorced separated Number of Children: _____

Emergency Contact (Name, Tel. & Relationship): _____

How did you hear about us? _____

Current Health

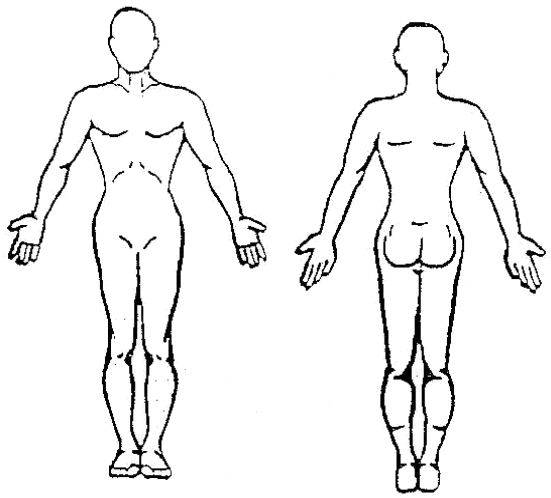
Current complaint(s) - in order of importance to you

1) _____

2) _____

3) _____

On the drawings to the right mark all painful areas with an **X**



Describe the pain:

- ❑ Sharp & Stabbing
- ❑ Pins & Needles
- ❑ Numbness
- ❑ Burning
- ❑ Dull ache
- ❑ Stiff & Tight

How long have you had this injury? _____

Have you had it before? ❑ No ❑ Yes

Circle a number on the following scales
(0 = no pain, 10 = worst pain)

Level of Pain Now	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Level of Pain at its Worst	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
General level of Stress	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Patient Name: _____

Name of Family Physician: _____
Is it okay to contact your doctor regarding your physical health? ❑ Yes ❑ No

Previous Assessment &/or Treatment for this complaint(s): _____

_____

Results? _____

Does this problem interfere with:
Work? ❑ Yes ❑ No Family or social time? ❑ Yes ❑ No Your hobbies or sports? ❑ Yes ❑ No

Current **exercise routine** (type of activity, frequency, duration): _____

_____

Goals of seeking therapy: _____

_____

List any **medications, supplements** (vitamins, etc) that you are currently taking: _____

_____

Are you currently experiencing any ongoing medical conditions? _____

_____

Do you wear Orthotics? ❑No ❑Yes - if YES, how long have you had them? _____

Do you smoke? ❑No ❑Yes

Are you pregnant? ❑No ❑Yes

Sleep: Hours per night _____

List any previous **Accidents/ Traumas** and the year(s) they occurred	List any previous **Fractures** and the year(s) they occurred	List any previous **Surgeries** and the year(s) they occurred
(1) _____	(1) _____	(1) _____
(2) _____	(2) _____	(2) _____
(3) _____	(3) _____	(3) _____

Our Fees

Type of Appointment	Length of Appointment	Fee
Initial Visit: Consultation & Examination & Treatment (time permitting)	55 Minutes	$130
Treatment (Including: Chiropractic, Manual Therapy, Laser Therapy, Functional Release, Graston Technique, Rehabilitation Exercise)	25 / 40 / 55 Minutes	$65 / $100 / $130
Custom Orthotics (Includes: Consultation, Examination & Orthotics)	55 Minutes	$500
Functional Range Conditioning (F.R.C.) teaching/exercise session	55 Minutes	$130

- **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** Payment can be made by cash, cheque, debit, credit, and direct billing (when applicable).
- **24 HOUR NOTICE** is required for appointment cancellation, otherwise the full fee will be charged.

Privacy Consent Form

For Collection, Use and Disclosure of Patient Personal Information

We value the trust you have placed in us and are taking all appropriate measures to safeguard your personal information and confidence. We have established a privacy policy to ensure that your personal information and personal health information is protected. Our privacy policy is available at our reception and at *www.satoriwellness.com*. In accordance with our privacy policy, we request that you provide your consent as set out below.

I agree that Dr. Michael Berenstein and Satori Health & Wellness can collect, use and disclose my personal information and personal health information provided by me in this client health inquiry history form to provide me with the services I request, to verify your visits for health insurance purposes, and for the other limited purposes set out in Satori Health & Wellness' privacy policy.

I hereby give my consent for a consultation and examination. I am also aware that Satori Health & Wellness will bear no responsibility in the event of any injury or harm that may occur as a result of treatment reasonably and professionally administered. I acknowledge that Satori Health & Wellness will not be responsible for any lost or stolen personal belongings.
I declare I will inform Satori Health & Wellness if there are any changes in my health history, upon my next visit.

Patient Consent

By my signature below I, _____ (Patient) hereby agree that Dr. Michael Berenstein and Satori Health & Wellness may collect, use and disclose my personal information in the manner set out above, and in accordance with our Privacy Policy.

Date _____ _____

SIGNATURE of patient / guardian

_____

Signature of witness