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Accident Rehabilitation Centre

PERSONAL AND ACCIDENT INFORMATION

Last Name:_____ First Name:_____

Address:_____ City: _____

Postal Code:_____ Alberta Health Care#: _____

Extended Health Care Benefits (Blue Cross, Sunlife, Great West Life, etc):_____

Age:_____ Date of Birth: (dd/mm/year) _____ Sex: ☐ M ☐ F

Home Phone:_____ Cell Phone: _____

Email Address:_____ Work Phone: _____

Occupation:_____ Driver's License: _____

If under 18 Parent or Guardian (Name and Phone #)_____

Emergency Contact: Name (Name and Phone #)_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for Visit?_____

When did the condition begin?_____

Have you ever had similar problems?

☐ Yes ☐ NO

Have you had X-Rays, MRI or other tests for this condition?? What Tests: Where and When?

_____

_____

Motor Vehicle Accident: ☐ Yes ☐ No Date of Injury: _____

Did you report the accident to the police: ☐ Yes ☐ NO

Did you receive medical attention immediately following the accident ☐ Yes ☐ NO

Is this condition related to: (WORK? WCB) ☐ Yes ☐ NO

Has your employer been notified? ☐ Yes ☐ No

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Please provide a brief description of the accident? _____

Can you perform your daily home activities? ☐ All ☐ Some ☐ Not at all

Can you perform your daily work activities? ☐ All ☐ Some ☐ Not at all

Describe your stress level: ☐ None ☐ Mild ☐ Moderate ☐ High

Sleep Pattern: ☐ Satisfactory ☐ Occasionally Disturbed ☐ Mostly Disturbed

Do you Exercise? ☐ Daily ☐ Occasionally ☐ Not at all

Do you consume alcohol ☐ Yes ☐ No How many per week? _____

Coffee: ☐ Yes ☐ No How many per day? _____

Do you Smoke? ☐ Yes ☐ No How many per day?_____ Street Drugs: ☐ Yes ☐ No

Please list any previous hospitalizations (Operation Illnesses, and Injuries? Year)

What type of medical attention did you receive and when?

Family Doctor name:_____

Emergency Contact? (Name & Phone number) _____

Referred to this office by? _____

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List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.)

Please list Drug Allergies? (Drug & Reaction)

Please list any other Allergies: (Allergen & Reaction)

List Name (s) and Numbers of doctor(s) you have seen for this injury:

Did you lose consciousness? ☐ Yes ☐ No How long? _____

Have you lost any time from work due to this injury? ☐ Yes ☐ No How long? _____

What part(s) of the body are injured? (BE SPECIFIC): _____

Have you received any treatments/therapies for this injury? ☐ Yes ☐ No
If yes please give names and phone numbers where you were treated: How Long?
(Chiropractic Care, Physio Therapy, Massage Therapy)

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Select activities which aggravate your condition:

☐ Standing ☐ Lying down ☐ Walking ☐ Sitting

☐ Bending ☐ Lifting ☐ Twisting ☐ Coughing

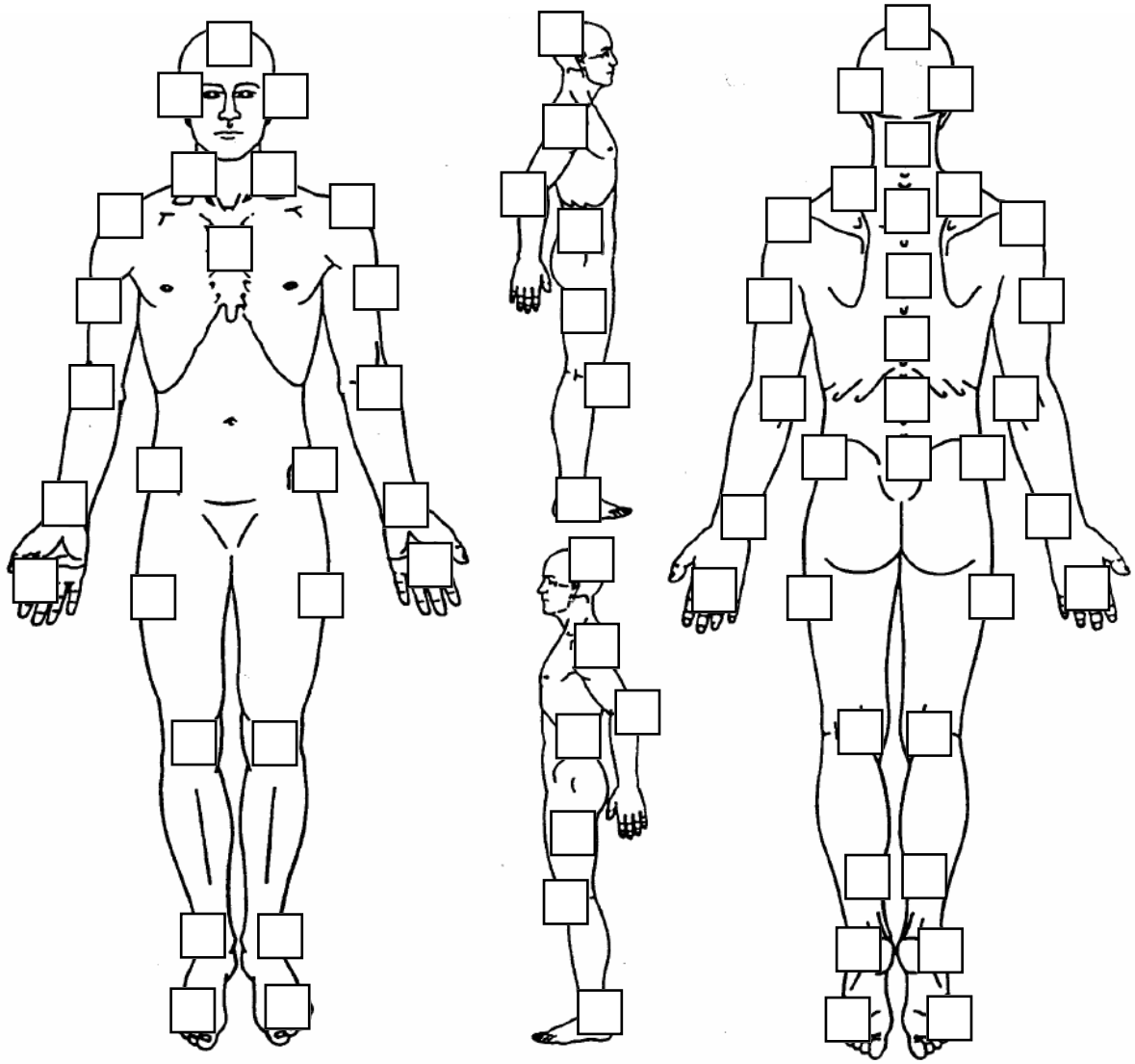
PLEASE MARK YOUR AREA OF COMPLAINT(S) AS FOLLOWS:

☐ ACHE ☐ BURNING ☐ NUMBNESS ☐ PINS & NEEDLES ☐ STABBING ☐ OTHER

PLEASE RATE YOU PAIN ON A SCALE OF 1 – 10

1 BEING NO PAIN AND 10 BEING TOTALLY UNABLE TO FUNCTION

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10



Systems Review

Patient Name: _____ **Date:** _____

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders swollen joints	Birth control pills
Enlarged glands	Spinal curvature	Miscarriages
	Arthritis	Complications with pregnancy
	Fractures	Pregnant? Y / N Week?
		Other:

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PATIENT AND INSURANCE INFORMATION

Patient Name: _____ Phone:_____

Are you the party at fault? ☐ **Y** / **N** ☐

Auto Insurance Info

Auto Insurance:_____

_____

Adjuster:_____

Claim #:_____

Phone:_____

Fax:_____

Date of Injury:_____

Extended Healthcare

Insurance Company:_____

Coverage Available: Chiro _____% annual to amount of $_____

Massage _____% annual to amount of $_____

Physio _____% annual to amount of $_____

Lawyer

Name:_____

_ Phone:_____

Fax:_____

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Your health is the most important thing at Accident Rehabilitation Centre. We also feel that it is important to explain our office fee schedule and what Alberta Health Care subsidizes for certain services. The following is a list of Accident Rehabilitation Centre's charges:

Protocol Visit (10 or 12)	**Cost**
Adjustment	$83.00
Physiotherapy (First 7 Visits)	$83.00
Rehabilitation (First 7 Visits)	$83.00
Physiotherapy (After 7 Visits)	$41.00
Rehabilitation (After 7 visits	$41.00
Massage Therapy (Half-Hour)	$70.00
GST	$3.50
Massage Therapy (Full Hour)	$97.00
GST	$4.25

Section B	**Cost**
Adjustment	$60.00
Physiotherapy	$110.00
Massage Therapy (Half Hour)	$70.00
GST	$3.50
Massage Therapy (Full Hour)	$97.00
GST	$4.25

Private & Other Fees/Services	**Cost**
Adjustment	$60.00
Physiotherapy	$85.00
Massage Therapy (Half Hour)	$70.00
GST (5%)	$3.50
Massage Therapy (Full Hour)	$97.00
GST (5%)	$4.25
Gunn IMS	$85.00
No Show Fee/Late or Cancelation (Less than 24 hr Notice) **PER PROVIDER**	$30.00
Annual Facility Fee	$350.00

Please note that charges are subject to change without warning

You are responsible for all charges, however; we shall assist you in recovering these charges from your insurer/Extended Healthcare. If you are unable to pay for treatment (or have exhausted your insurance benefits/Alberta Health) and have a personal injury claim, we may be able to 'carry' your charges until settlement of your claim, at which time ARC would be paid in full (under a signed agreement called an 'Assignment of Proceeds'). Any remaining charges will be sent to your specific insurance company.

Initial: _____

Date: _____

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Fee Sheet Continued

In the event that you incur charges that are neither recovered nor recoverable from your insurer , Extended Health Care or Alberta Health, you promise to pay the Accident Rehabilitation Centre Inc. the full amount of those charges together with an interest rate of 1% per month, calculated monthly (12.68% annually) plus all costs incurred by Accident Rehabilitation Centre Inc. in attempt to recover those charges (legal fees and disbursements, if any).

We are happy to assist you with your insurance forms or any questions you may have regarding your Section B benefits.

Thank you for your cooperation

Signature:

× _____

Name: _____

Date: _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a

damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

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ACUPUNCTURE AND/OR INTRA-MUSCULAR STIMULATION

(IMS) CONSENT FORM

Acupuncture and IMS are medical treatments performed by the insertion of needles through the skin to release shortened bands of muscle caused by abnormal functioning of the nervous system. This will ultimately help with pain relief. No drugs are injected.

Like any medical procedure, there are possible complications. Although these are rare in occurrence, they are real and must be considered prior to giving consent to the procedure. Any time a needle is used there is a risk of infection. To minimize this risk, we use special individually wrapped single use sterile needles, which are discarded after each use in a special sharps container. As such, infection is rare. A needle may be inadvertently inserted in an artery, nerve or vein. If an artery or vein is punctured, a bruise may develop. If a nerve is punctured, it may cause paresthesia (a prickling sensation) which may continue for days. When a needle is placed close to the chest wall, there is rare possibility of pneumothorax (air in the chest wall). Fortunately, all these complications are rare, not fatal and readily reversible.

You may experience an increase in pain and/or soreness for one or two days, followed by improvement in overall pain state. The increased pain is related to overactive shortened muscle bands that have not been released.

I have made my physical therapist aware if I am or may be pregnant, am taking blood thinners, am a haemophiliac, or have a cardiac pacemaker.

I hereby certify that I understand the above authorization and the risks of possible complications. All relevant questions have been answered satisfactorily by my treating physical therapist. I am aware that I may withdraw this consent and stop treatment at any time.

I, _____(Print name), hereby give my voluntary consent to receive treatment with acupuncture and/or IMS.

X_____SIGNATURE OF PATIENT _____DATE

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND X-RAYS

TO WHOM IT MAY CONCERN:

This is to authorize any physician, hospital, nurse, neurologist, orthopedist or other medical personnel/facility to furnish the Accident Rehabilitation Centre or their duly authorized representative, all medical records (including but not limited to, prescription orders, physician notes, therapy notes, reports) and x-rays along with any other information pertaining to the conditions
of:_____

_____

You are hereby authorized to furnish all information as may be requested by my physician or allow him or his representative to copy x-rays or other medical records concerning my condition and treatment. A copy of this authorization shall have the same force and effect as the original and shall remain in effect until otherwise revoked.

_____
Date

_____ _____

Patient Signature (Legal Guardian) Printed Name:
(please print)

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CANCELLATION/MISSED APPT POLICY

24-hour notice is required to cancel and appointment

Failure to give notice may have you incur a late cancellation fee of $30.00 per provider and must be paid to the provider at your next appointment.

If you miss an appointment that you have confirmed, you will be charged $30.00 per provider which must be paid to the provider at your next appointment.

If you are on assignment of funds with your lawyer this fee will automatically be charged to your account.

Dr. Vant late, cancel or no-shows are subject to a $75.00 charge.

_____ _____

Signature **Date**