A R C
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? ☐ Yes ☐ No ☐ Not at all

Can you perform your daily work activities? ☐ Yes ☐ No ☐ 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 place(s) and 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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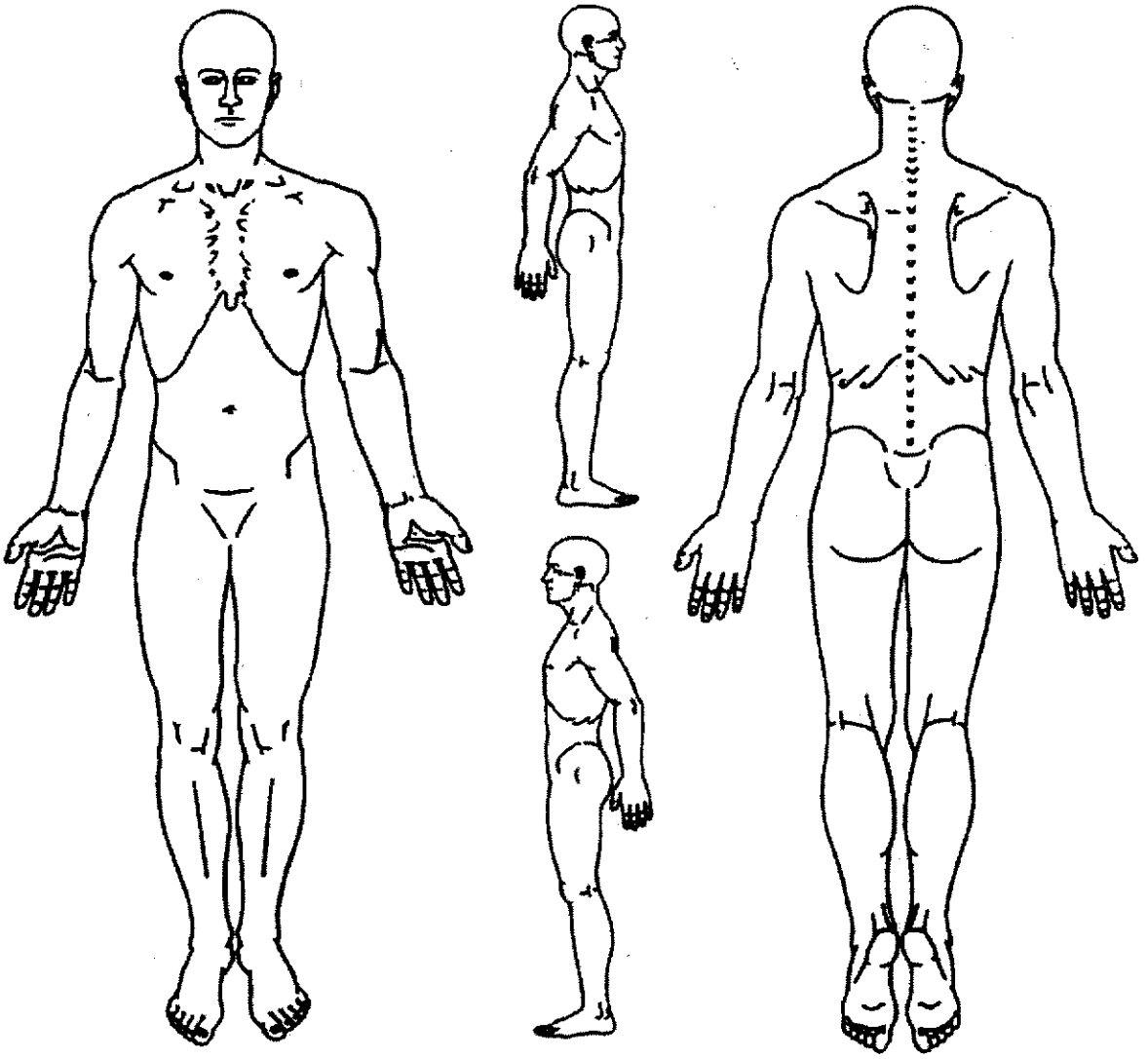
Circle activities which aggravate your condition:

Standing	Lying down	Walking	Sitting
Bending	Lifting	Twisting	Coughing

PLEASE CIRCLE YOUR AREA OF COMPLAINT(S) AS FOLLOWS:
A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES S = STABBING O = 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



Patient Name..... ***Date***.....

Please ***circle*** any conditions that are ***presently*** causing you a problem and **underline** those that have caused you problems in the **past.**

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

Attorney

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. The following is a list of Accident Rehabilitation Centre's charges:

Protocol visits (10 or 21)		**Outside Protocol Visits**		**Other Fees/Services**	
Adjustment	$38.00	Adjustment	$55.00	Injury Recall/Active Release	$35.00
Adjustment new (First 7 visits)	$83.00				
Adjustment new (After 3/7 visits)	$41.00				
Physiotherapy(First 7 Visits)	$83.00	Physiotherapy	$105.00	Acupuncture	$65.00
Rehabilitation(First 7 Visits)	$83.00				
Physiotherapy(After7 Visits)	$41.00	Rehabilitation	$85.00	No Show Fee	$25.00
Rehabilitation(After 7 Visits)	$41.00			**Annual Facility fee for Assignment**	**300.00**
Massage Therapy (1/2 Hour)	$65.00	Massage Therapy (1/2 Hour)	$65.00		
GST 5%	$ 3.25	GST 5%	$ 3.25		
Massage Therapy (1 Hour)	$94.00	Massage Therapy (1 Hour)	$94.00		
GST 5%	$ 4.70	GST 5%	$ 4.70		

You are responsible for all charges however we shall assist you in recovering these charges from your insurer/Extended Health Care provider. If you are unable to pay for treatment (or have exhausted your insurance benefits) 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.

In the event that you incur charges that are neither recovered nor recoverable from your insurer or Extended Health Care provider, 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%) per annum 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 (Please Print): _____

DATE: _____

CONSENT TO CHIROPRACTIC TREATMENT

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.

_____
Name (Please Print)

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

_____ Date: _____ 20____
Signature of Chiropractor

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AFCI Informed Consent for Acupuncture Treatments

Please read carefully-

I hereby request and consent to the performance of Acupuncture and other related techniques, as necessary, including dry needling (GGT technique) moxibustion, cupping and/or electroacupuncture.

Before treatment, ensure that you have had a light meal within the previous few hours. Avoid smoking and consumption of alcohol or caffeine for a few hours before and after treatment.

I understand and am informed that in the practice of acupuncture there are some risks to treatment including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, or fainting. These symptoms are temporary in nature. On rare occasions, infections, convulsions, possible perforation of internal organs, and struck or bent needles could occur,

I have been advised that only single use, sterile, disposable needles are to be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications. I wish to rely on the practitioner to exercise the facts then known, is my best interests. I understand that the results are not guaranteed. I have read the above consent form. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the above-mentioned acupuncture procedure.

N.B. Female Patients: I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment (s) is possible. I hereby states that I am not pregnant, nor is there any possibility that I may be pregnant.

_____

Date Signed

_____ _____

Patient Signature **Witness Signature**

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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 my doctor, _____ or his 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 condition 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)