



Please Print All Information

## **PERSONAL AND ACCIDENT INFORMATION**

Name:	Today's Date:
Address:	
City/Province/Postal Code:	
Email Address:	
Home Phone:	Pager/Cellular Phone:
Work Phone:	
Date of Birth: (m/d/y)	AHC #:
If Under 18 Parent/Guardian:	
Emergency Contact:	
Phone #:	

### **Injury Information**

Is this injury WCB related? **Y / N**

Date present injury occurred ( <b>DOI</b> ):	Time:	AM/PM
In the patient's words – What happened? (BE SPECIFIC):		
Who witnessed the accident?		
Did you report the accident to Police?	When?	
Did you receive medical attention immediately following the accident? <b>Y / N</b>		



What type of medical attention did you receive?
List name(s) and numbers of place(s) and doctor(s) you have seen for this injury:
Did you lose consciousness?                      How long?
What part(s) of the body are injured? (BE SPECIFIC):
Circle activities which aggravate your condition:    standing    lying down    walking
sitting    bending    lifting
twisting    coughing
Have you lost any time from work due to this injury?                      How long?
Have you received any treatments of therapies for this injury? <b>Y / N</b> If <b>YES</b> , give names and phone numbers of doctors/facilities where you were treated:
What type of treatments or therapies did you receive?
How long did you receive therapy?                      days                      weeks                      months

## ACCIDENT REHABILITATION CENTRE

<b>PATIENT REGISTRATION / HEALTH QUESTIONNAIRE</b>		<b>DATE</b>
Name	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	Alberta Health Care#
Date of Birth	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Street Address	City	Postal Code
Occupation/ Employer	Extended Health Insurance #	
Spouse's Name	Spouse's Occupation	
If Under 18 Parent/Guardian		
Emergency Contact		
Phone # (   )	Referred to this Office by	

### HEALTH QUESTIONNAIRE

<b>REASON FOR VISIT</b>	
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<b>FAMILY HISTORY</b>	<i>If any relative has suffered any of the following, please circle the number &amp; indicate which relative</i>
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1) Epilepsy (seizures)	11) Arthritis	
2) Migraine headaches	12) Osteoporosis (weak bones)	
3) Mental Illness	13) Heart Disease	
4) Glaucoma	14) Stroke	
5) Diabetes	15) High Blood Pressure	
6) Thyroid Disease (goiter)	16) High cholesterol	
7) Hayfever	17) Alcoholism	
8) Asthma	18) Genetic Disorder	
9) Anemia	19) Cancer (type)	
10) Bleeding Disorder	20) Eczema    21) Psoriasis	

<b>HOSPITAL ADMISSIONS</b>	<i>Indicate the year of hospitalization and the reason, do not include normal pregnancies</i>
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Year	Illness or Operation	Year	Illness or Operation	Year	Illness or Operation

<b>MEDICATIONS</b>	<i>Note dosage and how many time / day you take them</i>	<b>DRUG ALLERGIES</b>
<b>List all medications that you are taking. Include those you buy/use without a prescription</b>		<b>Drug</b> <b>Reaction</b>
		<b>OTHER ALLERGIES</b>
		<b>Allergen</b> <b>Reaction</b>

<b>MEDICAL HISTORY</b>	<b>MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE IF HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.</b>		
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<input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Unusual fatigue- loss of energy <input type="checkbox"/> Headaches- <i>severe</i> <input type="checkbox"/> Migraine <input type="checkbox"/> Dizzy or <input type="checkbox"/> Fainting spells <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in ear <input type="checkbox"/> Ear infections- <i>frequent</i> <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Double or blurred vision <input type="checkbox"/> Nose bleeds- <i>frequent</i> <input type="checkbox"/> Sinus pain <input type="checkbox"/> Sore throat <input type="checkbox"/> Teeth/gum pain- bleeding <input type="checkbox"/> Hoarseness <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Hayfever/allergies <input type="checkbox"/> Pneumonia/pleurisy <input type="checkbox"/> Asthma/wheezing Shortness of breath- <input type="checkbox"/> On exertion <input type="checkbox"/> lying flat <input type="checkbox"/> Chest pain or tightness <input type="checkbox"/> High Blood pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> High cholesterol/fat	<input type="checkbox"/> Swollen ankles <input type="checkbox"/> Calf pain- when walking <input type="checkbox"/> Varicose veins/phlebitis <input type="checkbox"/> Loss of Appetite- recent <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Indigestion or heartburn <input type="checkbox"/> Persistent nausea/vomiting <input type="checkbox"/> Peptic ulcer/abdominal pain <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Jaundice/ hepatitis <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bowel polyps <input type="checkbox"/> Chrohn's/colitis <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Urine infections- <i>frequent</i> <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Venereal disease/ genital warts <input type="checkbox"/> Urethral discharge <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Convulsions/seizures <input type="checkbox"/> Tremor/hands shaking	<input type="checkbox"/> Muscle weakness <input type="checkbox"/> Numbness/tingling sensations <input type="checkbox"/> Arthritis/rheumatism <input type="checkbox"/> Back pain- <i>frequent</i> <input type="checkbox"/> Bone fracture/joint injury <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Foot pain <input type="checkbox"/> Cold numb feet <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sleeping- <i>difficulty</i> <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Memory <input type="checkbox"/> Phobias <input type="checkbox"/> Moodiness <input type="checkbox"/> Stress-excessive <input type="checkbox"/> Mental illness <input type="checkbox"/> Chicken pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German measles <input type="checkbox"/> Pheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Contact with blood or body fluids <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Sexual problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes	<b>Males</b> <input type="checkbox"/> Prostate PSA test____  <b>Females- Please complete</b> Menstrual Flow: Age Started:_____ <input type="checkbox"/> Reg <input type="checkbox"/> Irreg <input type="checkbox"/> Pain/cramps Days of flow_____         Length of cycle_____         Date- 1 <sup>st</sup> day of last period _____ Currently pregnant Yes <input type="checkbox"/> No <input type="checkbox"/> Breast Feeding Yes <input type="checkbox"/> No <input type="checkbox"/> Number of- Pregnancies_____ Abortions_____ Miscarriages_____ Live Births_____ <input type="checkbox"/> Pain/bleeding with sex Birth Control Method_____ If <b>B.C.</b> pill (name)_____ <input type="checkbox"/> Infertility history <input type="checkbox"/> Flushing menopause Date of last PAP test_____ Date of last mammogram _____
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<b>HABITS</b>	Cigarettes- pkg/day		# Years Smoking		Quit smoking-year		Pack Years		Alcohol- Drinks/Week	
	Coffee- cups/day		<b>Regular Exercise</b> <input type="checkbox"/> yes <input type="checkbox"/> no							
<b>Sleep Pattern</b> <input type="checkbox"/> Satisfactory <input type="checkbox"/> Occasionally Disturbed <input type="checkbox"/> Mostly Disturbed						<b>Street Drugs</b> yes <input type="checkbox"/> no <input type="checkbox"/>				



Accident Rehabilitation Centre

### PATIENT AND INSURANCE INFORMATION

Patient Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell 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: \_\_\_\_\_





Accident Rehabilitation Centre

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:

<b><u>Protocol visits (10 or 21)</u></b>		<b><u>Outside Protocol Visits</u></b>		<b><u>Other Fees/Services</u></b>	
Adjustment	\$37.00	Adjustment	\$49.00	Injury Recall/Active Release	\$35.00
Physiotherapy(First 7 Visits)	\$80.00	Physiotherapy	\$100.00	Acupuncture	\$65.00
Rehabilitation(First 7 Visits)	\$80.00				
Physiotherapy(After 7 Visits)	\$40.00	Rehabilitation	\$85.00	No Show Fee	\$20.00
Rehabilitation(After 7 Visits)	\$40.00			Dr. Vant No Show Fee	\$55.00
Massage Therapy (1/2 Hour)	\$50.00	Massage Therapy (1/2 Hour)	\$52.00		
GST 5%	\$52.50	GST 5%	\$54.60		
Massage Therapy (1 Hour )	\$75.00	Massage Therapy ( 1 Hour)	\$79.00		
GST 5%	\$78.75	GST 5%	\$82.95		

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 18% 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:** \_\_\_\_\_



Accident Rehabilitation Centre

INFORMATION CONSENT TO CHIROPRACTIC  
TREATMENT ACCIDENT REHABILITATION CENTRE

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament sprains or strains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries indentified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by the spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries of complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all present and future chiropractic care.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Patient Signature (Legal Guardian)

\_\_\_\_\_  
Witness of Signature

Name: \_\_\_\_\_  
(please print)

Name: \_\_\_\_\_  
(please print)



## **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, in 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.

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**Date Signed**

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**Patient Signature**

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**Witness Signature**



Accident Rehabilitation Centre

**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: \_\_\_\_\_

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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)