



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? _____



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)

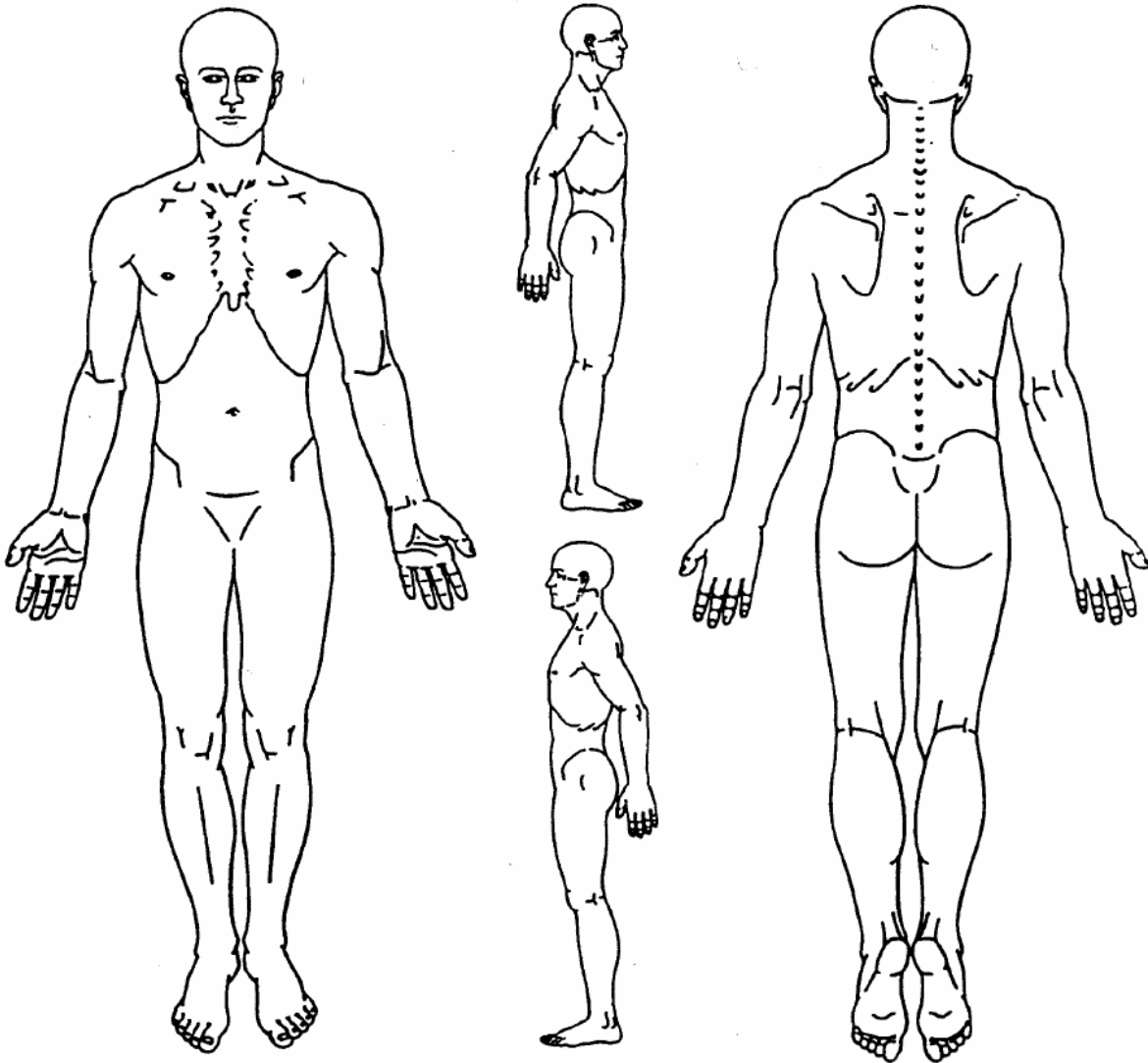


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Select activities which aggravate your condition:

- | | | | |
|----------|------------|----------|----------|
| Standing | Lying down | Walking | Sitting |
| Bending | Lifting | Twisting | Coughing |

PLEASE MARK YOUR AREA OF COMPLAINT(S) AS FOLLOWS:
A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES S = STABBING O = OTHER
PLEASE RATE YOUR 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 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
EYES, EARS, NOSE, THROAT	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 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: _____



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 and what Alberta Health Care subsidizes for certain services. The following is a list of Accident Rehabilitation Centre's charges:

Protocol Visit (10 or 21)	Cost	Section B	Cost	Private & Other Fees/Services	Cost
Adjustment	\$83.00	Adjustment	\$60.00	Adjustment	\$60.00
Physiotherapy (First 7 Visits)	\$83.00	Physiotherapy	\$110.00	Physiotherapy	\$85.00
Rehabilitation (First 7 Visits)	\$83.00	Massage Therapy (Half Hour)	\$70.00	Massage Therapy (Half Hour)	\$70.00
Physiotherapy (After 7 Visits)	\$41.00	GST	\$3.50	GST (5%)	\$3.50
Rehabilitation (After 7 visits)	\$41.00	Massage Therapy (Full Hour)	\$97.00	Massage Therapy (Full Hour)	\$97.00
Massage Therapy (Half-Hour)	\$70.00	GST	\$4.25	GST (5%)	\$4.25
GST	\$3.50			Gunn IMS	\$85.00
Massage Therapy (Full Hour)	\$97.00			No Show Fee/Late or Cancellation (Less than 24 hr Notice) PER PROVIDER	\$30.00
GST	\$4.25			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: _____



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: _____



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



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 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)



CANCELLATION/MISSED APPT POLICY

24-hour notice is required to cancel your appointment(s)

Failure to give notice may have you incur a late cancellation fee of \$45.00 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 \$45.00 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 \$100.00 charge.

Signature

Date