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

A R C
Accident Rehabilitation Centre

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? _____

A R C
Accident Rehabilitation Centre

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)

A R C
Accident Rehabilitation Centre

Select activities which aggravate your condition:

☐ Standing ☐ Lying down ☐ Walking ☐ Sitting

☐ Bending ☐ Lifting ☐ Twisting ☐ Coughing

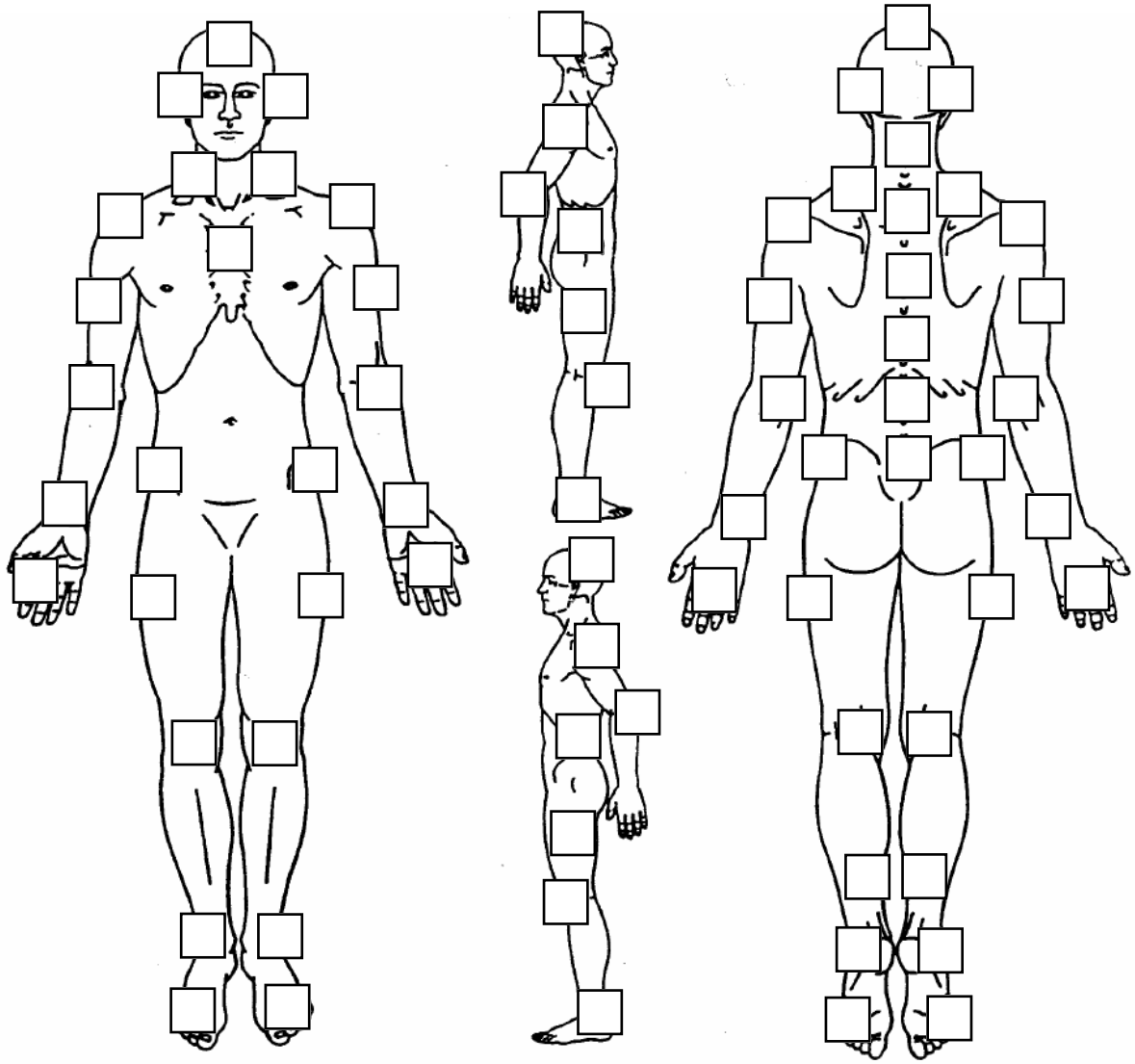
PLEASE MARK YOUR AREA OF COMPLAINT(S) AS FOLLOWS:

☐ 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:

ARC
Accident Rehabilitation Centre

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:_____

ARC
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 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	$70.00
Physiotherapy	$95.00
Massage Therapy (Half Hour)	$75.00
GST (5%)	$3.75
Massage Therapy (Full Hour)	$110.00
GST (5%)	$5.50
Gunn IMS	$95.00
No Show Fee/Late or Cancelation (Less than 24 hr Notice) **PER PROVIDER**	$65.00
Annual Facility Fee	$375.00

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: _____

A R C
Accident Rehabilitation Centre

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: _____

A R C
Accident Rehabilitation Centre

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 $65.00 per provider and must be paid to the provider at your next appointment. Notice via text-reminder must be at least 24 hours prior to appointment time to avoid fee. If you are unsure, please phone the clinic and we would be happy to assist you.

If you miss an appointment that you have confirmed, you will be charged $65.00 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, and are applied at the same discretion as outlined above.

_____ _____

Signature **Date**

A R C
Accident Rehabilitation Centre

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

ARC

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)