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Accident Rehabilitation Centre

# WCB INTAKE

## PERSONAL AND INCIDENT 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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**Mechanism of Injury/Incident Report** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

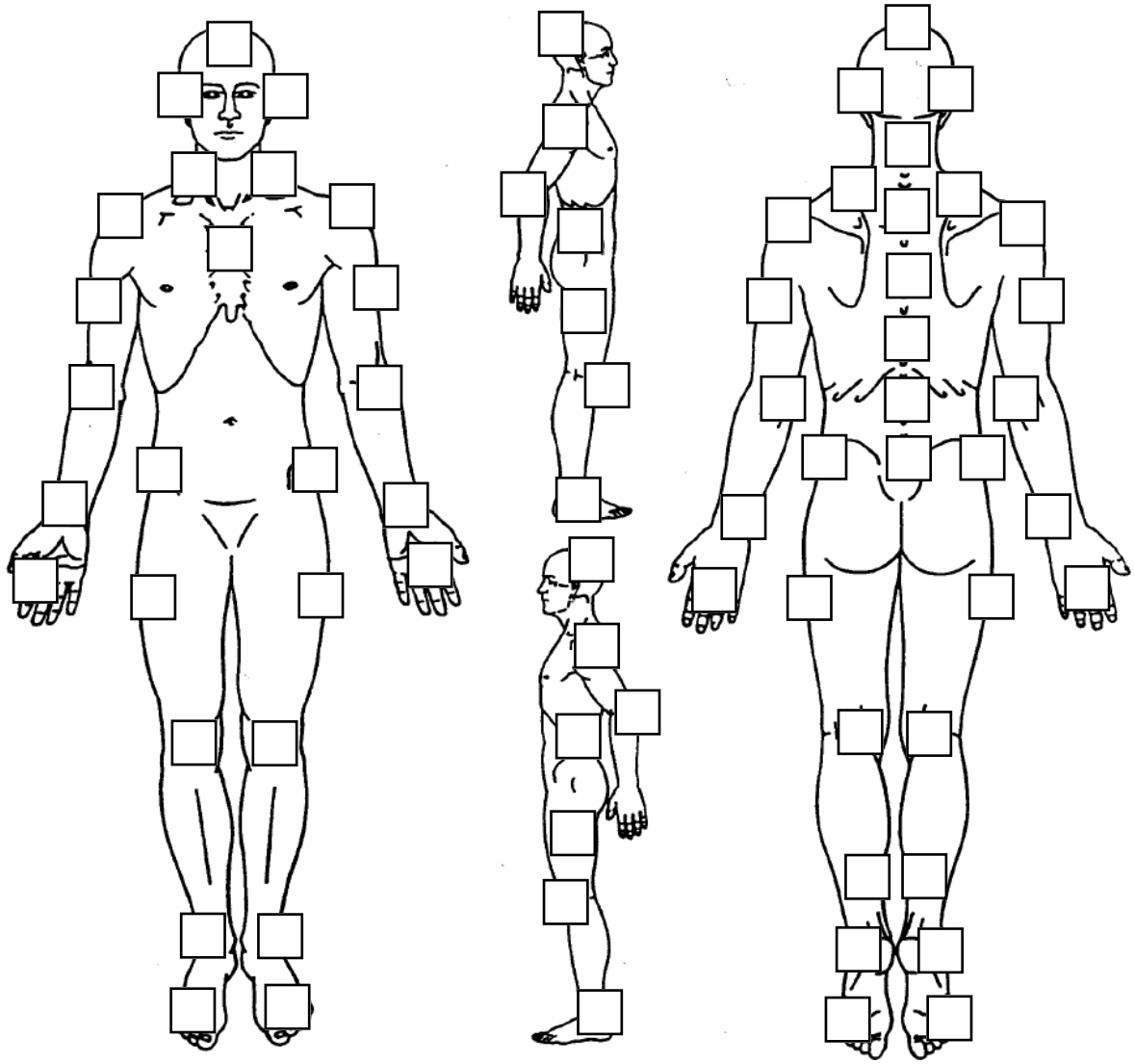
**PLEASE MARK YOUR AREA OF COMPLAINT(S) AS FOLLOWS:**

**☐ 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**



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# PATIENT AND EMPLOYER INFORMATION

Patient Name: _____ Phone:_____

WCB CLAIM? **Y / N** ☐ ☐

**Auto Insurance Info**

**Employer**_____

_____

**Address**:_____C

**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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# 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**