ACTION SPORTS CLINIC

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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.

_____ Date: _____ 20____.
Name (Please Print)

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

_____ Date: _____ 20____
Signature of Chiropractor

INFORMED CONSENT TO TREATMENT

Treatment Information

Physiotherapy treatment techniques may include, but are not limited to: manual therapy techniques including spinal manipulation, electrotherapeutic modalities, exercises as well as other techniques such as acupuncture or IMS/dry needling. A number of these may be recommended during your program. As your active participation in all aspects of treatment will be required to enhance your recovery, it is the policy of Action Sports Clinic to ensure the benefits, side effects and potential complications of each chosen treatment are explained to you by your physiotherapist before use. If at anytime you have questions regarding the recommended treatment or wish to stop treatment you must inform your therapist immediately so they can discuss the treatment rationale and/or modify your program accordingly.

I understand and agree with the above mentioned criteria and as such agree to participate in both the assessment and treatment program outlined by my physiotherapist at Action Sports Clinic. I understand that for the duration of my treatment, my consent may be withdrawn at any time and it is my responsibility to inform my physiotherapist.

I consent to participate in both the assessment and treatment. **Initials:** _____

Personal Information

Action Sports Clinic acts in accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA). The Professional Code of Conduct of doctors and physiotherapists limits the reporting of injuries, illnesses and other problems to anyone other than the individual concerned.

I give Action Sports Clinic my consent to release/obtain information from my doctor or insurance company with respect to my care by report, letter, phone, fax, email, or direct communication.

Initials: _____

Payment Information

I agree to be financially responsible for all the costs of assessment and treatments. In the instance that my claim is due to a motor vehicle accident and for some reason the third-party payer denies the claim and/or refuses to pay, any or the full amount billed, I am responsible for paying the amount outstanding.

I understand the cancellation/missed appointment policy, which states that if notice of cancellation is less than 24 hours prior to the appointment, I may be subjected to pay a fee equal to that of the treatment that was cancelled/missed.

Credit Card: _____ VISA:_____ MC:_____ Exp: _____

Charge Each Visit (Express check out):_____ Charge ONLY for late cancellation/missed:_____

_____ _____

Patient Name Date

_____

Patient Signature (or parent/guardian)

_____

Witness Signature

Action Sports Clinic
510 5th St. SW, Suite 215
Calgary, AB T2P 3S2

ACTION SPORTS CLINIC

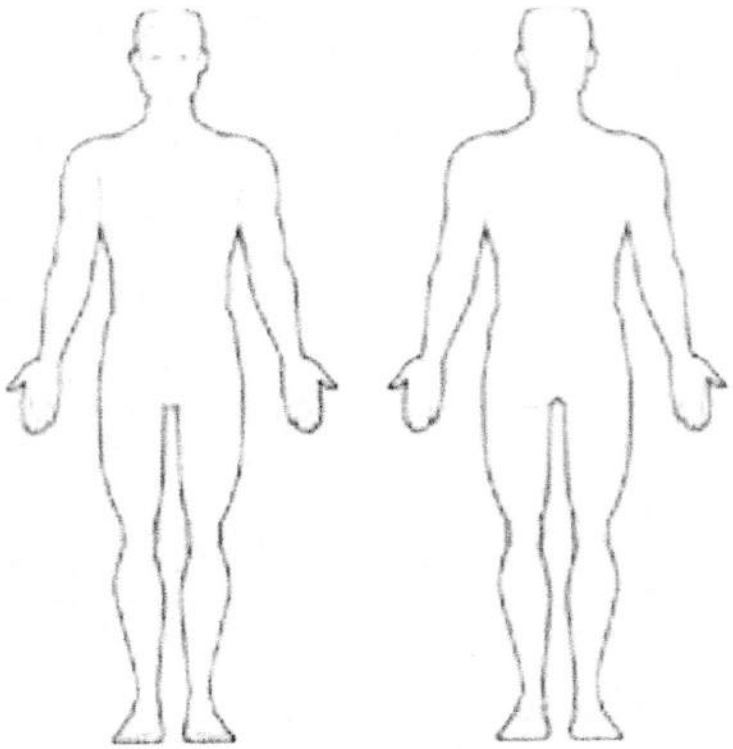
PATIENT INTAKE FORM

DATE: _____ NAME: _____ GENDER: M F
ADDRESS: _____
CITY: _____ PROV: _____ POSTAL CODE: _____
HOME: (____)_____WORK: (____)_____ CELL: (____)_____
E-MAIL: _____
CONSENT TO EMAIL YOU OUR NEWSLETTER AND OTHER COMMUNICATION? YES:_____NO:_____
ALBERTA HEALTH CARE #: _____ DATE OF BIRTH: DD _____ MM _____YYYY _____
OCCUPATION: _____ EMPLOYER: _____
EMERGENCY CONTACT: _____ PHONE #: _____

PRIOR CHIROPRACTOR/PHYSIOTHERAPY/MASSAGE THERAPY TREATMENT? YES: _____NO: _____
NAME OF PRACTITIONER: _____ XRAY'S TAKEN: YES:_____ NO: _____
RESULTS: (CIRCLE ONE) EXCELLENT GOOD FAIR POOR DATE: _____
FAMILY MEDICAL DOCTOR: _____ PHONE #: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? (CIRCLE ONE) WALK-BY INTERNET SIGNAGE PHONE BOOK
FAMILY FRIEND CO-WORKER NAME: (SO WE CAN THANK THEM) _____OTHER: _____

MEDICAL HISTORY: _____
FALLS & ACCIDENTS: _____
SURGERY & OPERATIONS: _____
FAMILY HEALTH CONDITIONS: _____
HAVE YOU EVER HAD ANY OF THESE? (CIRCLE ONE) HEART CONDITIONS STROKES ARTHRITIS
RESPIRATORY CONDITIONS DIABETES CANCER ASTHMA OSTEOPOROSIS HEPATITIS
ARE YOU PREGNANT? YES/NO ARE YOU USING BLOOD THINNERS? YES/NO
LIFESTYLE HABITS? SMOKER? YES/NO _____VITAMINS? YES/NO _____
MEDICATIONS? YES/NO _____EXERCISE? YES/NO _____ALLERGIES? YES/NO _____



MAIN PROBLEM: (PLEASE DESCRIBE IN YOUR OWN WORDS) _____

IS THIS CONDITION DUE TO AN INJURY? YES/NO
IF YES, PLEASE DESCRIBE:

IS THIS A WORK RELATED INJURY: YES/NO
DATE PAIN STARTED:

AREA(S) OF COMPLAINT: (PLEASE INDICATE ON DIAGRAM)

SENSATIONS FELT: (PLEASE CIRCLE)
ACHING? BURNING? NUMBNESS? STABBING? PINS & NEEDLES?

PAIN SCALE: (RATE THE SEVERITY OF YOUR PAIN)
NONE 1 2 3 4 5 6 7 8 9 10 EXCRUCIATING

COMMENTS _____