

Bridgeland Sport & Spine

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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 strains or sprains 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 with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by 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.

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 my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature(Legal Guardian)

Name: _____
(please print)

Witness of Signature

Name: _____
(please print)

BRIDGELAND SPORT & SPINE
EXPLANATION OF FEES

Procedure	Consists Of:	Prices for Treatment:
Initial Assessment & Treatment	-Discuss your health problem. -Review your case history and perform a physical examination. -Discuss the examination findings and treatment options. -Initial Treatment.	\$90.00
Active Release, Graston or Rehab exercise program	-Please ask for more information on this therapy. -Includes adjustment if appropriate.	\$60.00
Chiropractic Adjustment	-Joint Manipulation only.	\$45.00
Physiotherapy - Basic Session	-Includes modalities, supervised exercise, or basic therapy procedures.	\$65.00
Physiotherapy-IMS	-Please ask for more information on this therapy.	\$75.00
	-IMS Needling additional body parts	\$10.00
Form Completion	-Missed work letters, completion of general insurance forms.	\$20.00

Discounts are available for seniors & full time students. Pre-purchased packages are available to decrease the overall cost of your treatment plan.

Forms of Payment:

Patients are responsible for full payment at the time services are rendered. We accept Interac, Visa, MasterCard, personal cheque and cash. Any credit arrangements must be authorized in advance by the doctor. Workers' Compensation and motor vehicle accident injuries, please inquire regarding fees and policies.

Third Party Insurance Coverage:

Third party insurance (extended health care benefits) coverage varies from plan to plan. Please check with your provider for specific coverage details.

All professional services rendered are charged to the patient receiving care. We will supply you with statements, reports, or other documents for a fee, if applicable, as outlines above, to help you receive reimbursement from a third party.

Missed/Cancellation Appointment Policy

Our office requires 24 hours notice for cancellation of appointments with Dr. Hankins, Massage Therapy, Acupuncture and Physiotherapy. Appointments missed or cancelled without sufficient notice will be charged the cost of treatment.

<p>I consent to charge my credit card # _____ expiry date: _____ for missed appointments. Patient signature: _____</p>
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I have read, understood, and agreed to the fees and payment obligations as listed above.

Patient (or parent/guardian) signature

Date

Bridgeland Sport & Spine

Patient Name: _____

Date: _____

Please **circle** current symptoms and **check (✓)** those you have had in the past.

General Symptoms:

loss of consciousness
blackouts
headache
fever
sweats
fainting
dizziness
clumsiness
convulsions
loss of sleep
numbness, tingling or pain
nervousness
loss of weight

Muscles & Joints:

stiff neck
back ache
swollen joints
painful tailbone
foot trouble
shoulder pain
elbow pain
wrist pain
hip pain
knee pain
arthritis
weakness/loss of strength
difficulty swallowing

EENT:

blurred vision
failing vision
double vision
eye pain
deafness
earache
ringing/buzzing ears
asthma
frequent colds
sinus infection
enlarged glands
enlarged thyroid
slurred speech

Respiratory:

chronic cough
spitting up phlegm
spitting up blood
chest pain
difficult breathing

Cardiovascular:

bleeding disorders
high blood pressure
pain over the heart
stroke
hardening of arteries
varicose veins
swelling of ankles
poor circulation
heart/blood disease
angina

Genito-urinary:

trouble urinating
blood in urine
kidney infection
bedwetting
prostate trouble

GU for women:

painful periods
excessive flow
hot flashes
irregular cycle
cramps/backache
vaginal discharge
swollen breasts
lumps in the breast

Have you ever been on the birth control pill? Yes/No
Are you currently taking the birth control pill? Yes/No
Pregnancies _____
Children _____
Currently pregnant? _____

Skin:

rashes, itching
bruise easily
dryness
boils
hives (allergy)

Gastrointestinal:

poor appetite
indigestion
excessive hunger
belching or gas
nausea or vomiting
pain over the stomach
constipation
diarrhea
hemorrhoids/piles
jaundice
gall bladder trouble
intestinal worms
ulcer
diabetes

Have you ever had any fractures? Yes/No
Have you ever been in a car accident? Yes/No

Have you ever been hospitalized? Yes/No
Have you ever smoked in the past? Yes/No

Are you currently a smoker?
Yes/No

Do you take medication on a regular basis? Yes/No

If yes, what? _____

Please inform the doctor if you are HIV+ or have or did have cancer Yes/No

Bridgeland Sport & Spin Pain Scale

Patient Name: _____ Date: _____

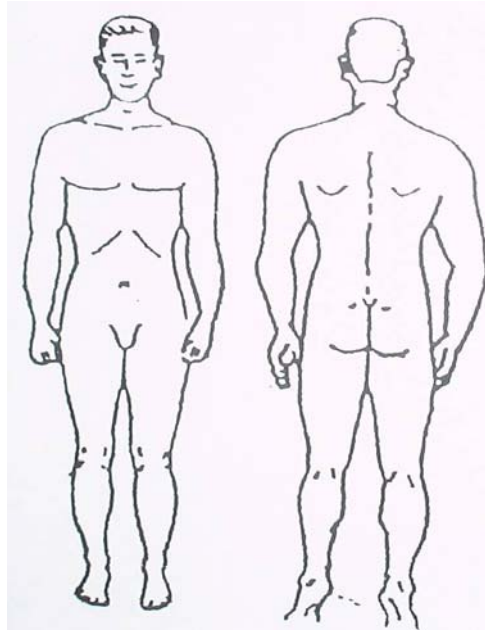
VISUAL ANALOGE SCALE (vas)

Please circle the number which best describes the severity of pain you are currently experiencing.

0 1 2 3 4 5 6 7 8 9 10
no pain excruciating pain

In the diagrams below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are currently experiencing. Please include all areas using the symbols provided below.

Symbols: numbness -----
burning XXXXX
stabbing and sharp ///////////////
dull and aching +++++
stiff and tight ~~~~~
pins and needles *****



O:

P:

Q:

R:

S:

T:

FamHx/NA:

Assoc. Sx:

Sports/Activities:

Previous HCP:

Dr. Notes: