

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ How did you hear about us? \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
 Occupation \_\_\_\_\_ Email (I agree to receive appointment reminders and clinic updates) \_\_\_\_\_  
 Birthdate (dd/mm/yr) \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Alberta Health Care Number \_\_\_\_\_  
**For your convenience, we can keep a credit card on file:** Card Type:  Visa  Mastercard  
 Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiry: \_\_\_\_/\_\_\_\_ CCV: \_\_\_\_\_

**EXTENDED HEALTHCARE COVERAGE**

Insurance Company Name \_\_\_\_\_ Group ID/Policy Number \_\_\_\_\_ Member Number \_\_\_\_\_  
 Relationship to Cardholder (self, spouse, child) \_\_\_\_\_ Name of Cardholder \_\_\_\_\_

**PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE**

Reason for appointment? \_\_\_\_\_

When did your condition begin? \_\_\_\_\_

Have you had X-rays, MRI or other tests? \_\_\_\_\_

Have you been tested positive for any blood-borne diseases? (HIV, AIDS, Hepatitis C, etc) \_\_\_\_\_ Yes No

Are you immunocompromised? Yes No Are you taking blood thinners? Yes No

Is this condition related to: Work? Yes No Has your employer been notified? Yes No

Motor vehicle accident? Yes No Date of injury: \_\_\_\_\_

Can you perform your daily home activities? Yes Yes, only with help Not at all

Can you perform your daily work activities? All Only some Not at all

Describe your stress level: None Mild Moderate High

Are you, or do plan to become pregnant? Yes No Unknown

Please list any previous surgeries, illnesses, injuries (motor vehicle accident): \_\_\_\_\_

Have you had previous physiotherapy? Yes No Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Family doctor name: \_\_\_\_\_

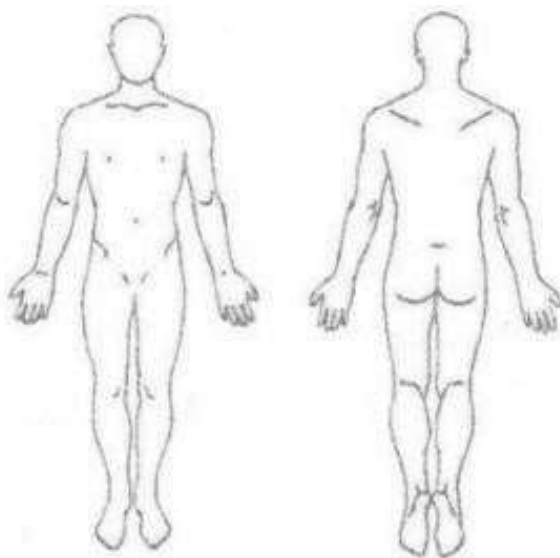
List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) \_\_\_\_\_

## HEALTH HISTORY QUESTIONNAIRE

**Have you ever been diagnosed or told you have any of the following?  
Please check the correct response:**

- |  |     |    |
|--|-----|----|
| 1. High blood pressure   | Yes | No |
| 2. Hardening of the arteries (arteriosclerosis)  | Yes | No |
| 3. Diabetes  | Yes | No |
| 4. Tuberculosis  | Yes | No |
| 5. Cancer, where? _____  | Yes | No |
| 6. Heart or blood diseases   | Yes | No |
| 7. Bone spurs on the neck bones (cervical sprain)  | Yes | No |
| 8. Osteoporosis  | Yes | No |
| 9. Whiplash injury (flexion-extension injury, cervical sprain)   | Yes | No |
| 10. Have you ever suffered a stroke?   | Yes | No |
| 11. Were you ever a smoker? From _____ To _____  | Yes | No |
| 12. Do you take any medication on a regular basis?   | Yes | No |
| 13. Visual disturbances (blurring, loss, double)   | Yes | No |
| 14. Hearing disturbances (loss, ringing, other noise)  | Yes | No |
| 15. Slurred speech or other speech problems  | Yes | No |
| 16. Difficulty swallowing  | Yes | No |
| 17. Dizziness  | Yes | No |
| 18. Loss of consciousness, even momentary blackouts  | Yes | No |
| 19. Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs or any other parts of the body | Yes | No |
| 20. Sudden collapse without loss of consciousness  | Yes | No |

**Indicate the location of your pain by shading the appropriate area:**



**Indicate the severity of the pain by selecting a number:**

0	1	2	3	4	5	6	7	8	9	10
<b>No Pain</b>										<b>Extreme Pain</b>



## CANADIAN PHYSIOTHERAPY ASSOCIATION

### Informed Consent for Physiotherapy and Functional Dry Needling Care

Valerie Lowe and Jakkie Yurchevich

Physiotherapists

403-474-7792

[www.evolvechiro.ca](http://www.evolvechiro.ca)

### **Physiotherapy**

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your physiotherapist and to make an informed decision about proceeding with treatment.

Physiotherapy treatment techniques may include, but are not limited to: manual techniques including spinal manipulation and joint mobilization, electrotherapeutic modalities and exercise as well as other techniques such as functional dry needling. A number of these may be recommended during your program. As your participation in all aspects of your program is imperative to its success, it is the policy of Evolve Chiropractic & Wellness Center to ensure the benefits, side effects and potential complications of each chosen modality are explained to you by your therapist before use. Throughout your program, if you have any questions or concerns about any recommended treatment you must inform your therapist immediately so they can explain the treatment rationale and/or modify your program appropriately. If at any time you choose not to participate in the program or any portion of it, you must inform your physiotherapist immediately. I understand that the results are not guaranteed.

#### **Benefits:**

Physiotherapy treatment has been demonstrated to be effective for pain and concerns originating from muscles, joints, nerves, or systemic conditions such as arthritis.

Treatment by your physiotherapist can help decrease pain and headaches, help restore mobility, range of motion and strength. It can also improve physical function and sport performance and reduce or eliminate the need for surgery or drugs.

#### **Risks:**

The risks associated with physiotherapy treatment vary according to each patient's condition as well as the location and type of treatment.

#### **The risks include but are not limited to:**

- **The temporary worsening of symptoms**-- Usually, any increase in pre-existing symptoms of pain or stiffness will only last 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 therapeutic modalities. 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.
- **Fracture**—Fracture is a rare occurrence that can occur with some joint mobilization/manipulation.
- **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. Physiotherapy treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, physiotherapy 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.

#### **Alternatives:**

Alternatives to physiotherapy treatment may include consulting other health professionals. Your physiotherapist 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 physiotherapist'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 physiotherapist immediately of any change in your condition.**

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**Patient Signature (or Legal Guardian)**

**Functional Dry Needling**

Functioning Dry Needling (FDN) involves inserting a single use sterile needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension and will promote healing.

**The risks include but are not limited to:**

The most serious risk with FDN is accidental puncture of a lung (pneumothorax). Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

\_\_\_\_\_  
**INITIALS**

**N.B. Female Patients:**

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

\_\_\_\_\_  
**INITIALS**

**Consent to Release Information:**

I give Evolve Chiropractic & Wellness Center my consent to release/obtain information from the following individuals with respect to my care by report, letter, phone, fax, email or direct communication:

- Physician(s)
- Employer
- Insurer
- Other

\_\_\_\_\_  
**INITIALS**

**Credit Card Holder Authorization**

I, the previously-named authorized credit card user, give Evolve Chiropractic and Wellness Center express authorization to charge my credit card for the purposes of 1) Payment for services rendered by any practitioner at Evolve Chiropractic and Wellness Center. 2) Payment for goods purchased from any practitioner at Evolve Chiropractic and Wellness Center. 3) Payment for any outstanding balance I may incur. I understand that this form constitutes a legally binding contract and that by affixing my signature to this form, I will be held responsible for all agreed upon (as stated above) charges as well as any and all collection and legal fees. This credit card is authorized for only the charges noted above.

\_\_\_\_\_  
**INITIALS**

**IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.**

I hereby acknowledge that I have discussed with the physiotherapist 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 physiotherapy treatment as proposed to me.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Patient Signature (or Legal Guardian)

\_\_\_\_\_  
Physiotherapist Signature