Pacific Rim Chiropractic Corporation

Member

Informed Consent to Chiropractic Treatment

Please read over the following consent form. **Should you have any questions or concerns after having read the form I will be happy to discuss them with you *before* you sign it.**

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. Recent studies suggest 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 in association 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 _____

X_____ _____
Patient Signature (Legal Guardian) Witness Signature

X_____ _____
Name of Patient (please print) Name of Witness (please print)

I hereby authorize Dr Ron Norman. MSc, DC access to medical imaging (X-Rays, CT, MRI Ultrasound) or laboratory reports that only pertain to my treatment at this office online via VIHA.

Patient or Guardian Signature:_____ Witness Signature:_____

Informed Consent Verified: _____

250-726-2220

Pacific Rim Chiropractic
Dr Ron Norman HBSc, BSc(Hons) MSc DC

WELCOME TO OUR OFFICE!

In order for us to help you, we ask for your *patience* while we spend the next few pages getting to know you better. This first page is a break down of the charges, while the following three include a history and an informed consent form.

If you have been injured at work, or from a recent motor vehicle accident, please tell us.

If you have extended health benefits through your employer, be sure to ask for a receipt after your treatments. If you are unsure, contact your employer. Most benefit programs include chiropractic care and will reimburse you.

OFFICE FEES:

First visit (includes consultation, examination and treatment)	$80
Subsequent office visit (chiropractic treatment)	$50
Rehabilitation (Active release or rehab session)	$85

MSP: ***Premium assistance*** (determined by the government of BC)

First visit (includes consultation, examination and treatment)	$55
Subsequent office visit	$25

After Hours or Emergency care: $100.00 minimum depending on time required

WCB Fees: $0 – Only a registered claim number is needed, WCB pays the doctor

MAINTENANCE PROGRAM
(HELPING YOU ACHIEVE YOUR OPTIMUM HEALTH)

After 10 visits in calendar year:

OPTIMUM HEALTH MAINTENANCE	**$45 (PER VISIT FOR REMAINDER OF YR.)**

All missed appointments or appointments cancelled *with less than 24 hour notice* will be subject to a $50.00 cancellation fee.

I have read the above fee schedule and understand my responsibility as a patient.

X_____ _____

Signature of patient/legal guardian Date

New Patient Intake Form

250-726-2220

Pacific Rim Chiropractic

Dr Ron Norman HBSc, BSc(Hons) MSc DC

Welcome to Pacific Rim Chiropractic. In order to help us extend to you the best care possible, please provide the following information:

Name_____ Care Card Number:_____

Full Home Address/City: _____

Home Phone:_____ Business Phone:_____

Emergency Contact:_____ Your Email:_____

Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F

Occupation:_____ Employer:_____

Family Physician:_____ Other health care providers: _____

Have you been treated by a chiropractor before? yes no Was it helpful? yes no

If yes, where and when was your last chiro treatment? _____

How did you hear about our office?_____

What is your main complaint today?_____

Is this condition work-related? yes no If yes, did you fill out an injury report? yes no

Is this condition result of a motor vehicle accident? yes no

What caused this condition?_____

How long has this condition been present?_____

What **relieves** this condition? nothing lying down walking standing sitting movement inactivity/rest other_____

What **aggravates** this condition? nothing lying down walking standing sitting movement inactivity/rest other_____

Have you received any other treatment for this condition?_____

Please list any medications or supplements you are taking currently: _____

_____

Please list any long-term medications that you have taken in the past:_____

Please list any serious illnesses or injuries: _____

Please list any surgeries:_____

Do you have a history of stroke/aneurysm heart disease rheumatoid arthritis blood clotting disorder use of blood thinners

Do any of these conditions run in your family? heart disease stroke high blood pressure cancer diabetes chronic fatigue/pain

Do you smoke? Yes/ No /Used to If yes, how many packs per day_____

Personal Health History

250-726-2220

Pacific Rim Chiropractic

Dr Ron Norman HBSc, BSc(Hons) MSc DC

To be able to create an accurate clinical picture of your current state of health, we need your complete health history. **All information will be kept strictly confidential**. Your responses will help determine in what ways chiropractic care can benefit you. Please check the degree of all conditions you currently have or have had in the past.

Blank = Never O= Occasional F= Frequent C= Constant

Muscle / Joint
O F C
____ Arthritis
____ Neck pain
____ Low back pain
____ Neck stiffness
____ Back stiffness
____ Pain between shoulders
____ Foot pain

Gastrointestinal
O F C
____ Belching or gas
____ Bloating
____ Colitis
____ Constipation
____ Diarrhea
____ Poor appetite
____ Nausea
____ Vomiting

Genitourinary
O F C
____Blood in urine
____Frequent urination
____ Incontinence
____ Kidney infections
____ Kidney stones
____ Painful urination

General
O F C
____ Dizziness
____ Fainting
____ Fatigue
____ Fever
____ Headache
____ Neuralgia
____ Night sweats
____ Poor Posture
____ Sciatica
____ Sweats
____ Tremors
____ Unexplained weight loss

Pain or Numbness in:
O F C
____ Shoulders
____ Arms
____ Elbows
____ Hands
____ Hips
____ Legs
____ Knees
____ Ankles
____ Feet
____ Heels
____ Back
____ Groin

Respiratory
O F C
____ Chest pain
____ Chronic cough
____ Difficulty breathing
____ Wheezing

Ear, Eye, Nose, Throat
O F C
____ Asthma
____ Colds
____ Ear ache
____ Ear discharge
____ Ear infections
____ Enlarged glands
____ Eye pain
____ Hoarseness
____ Hearing loss
____ Sinus infections

Cardiovascular
O F C
____ Ankle swelling
____ Heart attack
____ High blood pressure
____ Low blood Pressure
____ Poor circulation
____ Rapid heartbeat
____ Slow heartbeat

Please check any of the following conditions you have or have had:
_ Addiction to: _____
_ Anemia
_ Back Surgery when_____
_ Cancer_____
_ Diabetes
_ Eating disorder
_ Eczema
_ Epilepsy
_ Gout
_ Heart Disease
_ Multiple Sclerosis
_ Pacemaker
_ Stroke
_ Other_____