Back in Action
Chiropractic and Rehabilitation

Patient Name:
Date:

CONSENT TO PHYSIOTHERAPY TREATMENT

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 includes mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Physiotherapy treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your physiotherapy can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

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:

- 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.

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.

• 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

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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.

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.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSIOTHERAPIST

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 physiotherapist treatment as proposed to me.

_____
Name (please print)

_____ _____
Signature of patient (or legal guardian) Date

_____ _____
Signature of Physiotherapist Date

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PATIENT ADMITTANCE RECORD

THE INFORMATION YOU PROVIDE IS FOR THE CONFIDENTIAL USE OF THIS OFFICE AND WILL ONLY BE RELEASED WITH YOUR WRITTEN CONSENT OR IF YOUR TREATMENT IS COVERED UNDER THE WORKER'S COMPENSATION ACT.

Date: _____

☐ Male ☐ Female

Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____

Address: _____
STREET APT#

_____
CITY PROVINCE POSTAL CODE

Telephone: Residence ( ) _____ Business ( ) _____ Ext. ____ Cell ( ) _____

Email: _____

Date of Birth: _____/ _____/ _____ Marital Status: _____
DAY MONTH YEAR

# of Children (Name/ age): _____

Contact Person: _____ Telephone: ( ) _____

☐ Family Physician: _____ Telephone: ( ) _____

Address: _____
STREET CITY PROVINCE POSTAL CODE

☐ No Family Doctor
☐ Walk-In Clinic Doctor and Name of Clinic _____

Date of last Appointment: _____ Date of last Physical: _____

Who may we thank for referring you to our clinic? _____

What is your Occupation? _____

Employer: _____ Telephone: ( ) _____

Address: _____
STREET CITY PROVINCE POSTAL CODE

Does your work task contribute to your health problem(s)? YES ☐ NO ☐

Is this a Worker's Compensation Case (W.S.I.B.)? YES ☐ NO ☐
If **YES**, please provide Social Insurance Number _____

Is this a Motor Vehicle Accident Case (M.V.A.)? YES ☐ NO ☐

Do you have Extended Health Coverage? YES ☐ NO ☐
If **YES**, what Company? _____ Policy #: _____

Have you seen a Physiotherapist before? YES ☐ NO ☐

Physical/Recreational Activities? _____

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PATIENT HISTORY

Primary reasons for seeking physiotherapy care:

1) Where is most of the pain or discomfort? _____

2) Any other areas of pain or discomfort? _____

List any other health problems you may be experiencing at this time _____

Is this problem recurrent or is this the initial onset? _____

What do you feel caused this problem? _____

Complaints began when and how? _____

Have you seen other doctors for this condition? If yes, describe treatment and outcome of treatment:

_____

List any current medications you are presently taking:

_____

How long have you been taking them? _____

Have you had X-rays in the last six months? Yes☐ No☐

What parts of body did you have x-rays? _____

Did you have any other therapy done for this condition (chiro/physio/massage etc.)?_____

Any future appointments with Specialists/Surgeons? _____

Any future appointments for tests/imaging (i.e. MRI, Ultrsound, CT Scan etc.)? _____

List any and all hospitalizations, injuries, accidents or surgery you have had and when:

_____

Please circle the quality of complaint: Dull / Aching / Sharp / Shooting/ Burning / Throbbing / Deep / Nagging / Other _____

Does this complaint travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity of Pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

How frequent is complaint present, how long does it last? _____

What aggravates your condition? Sitting / Bending / Lying / Standing / Lifting / Walking / Cold / Heat

What relieves your condition? ☐ Massage / ☐ Adjustments / ☐ Cold / ☐ Heat / ☐ Other: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

_____

Do you have a regular exercise program? _____Do you take vitamins or supplements regularly? If so, please list_____

How do you sleep? On your side, back, or stomach? _____1/ 2 / 3/ pillows

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Patient Name:

General Systems Review

Respiratory

- Allergies
- Asthma
- Bronchitis
- Chest Pain
- Cough
- Emphysema
- Frequent Colds
- Hay Fever
- Pneumonia
- Smoker
- Trouble Swallowing

Skin

- Acne
- Boils
- Colour Changes
- Dermatitis
- Dryness
- Eczema
- Fungal Infection
- Herpetic Infection
- Itching
- Lumps
- Pain
- Polyps
- Psoriasis
- Rashes
- Scars
- Shingles
- Steroid Therapy
- Swelling

Vision

- Blurred Vision
- Cataracts
- Double vision
- Dyslexia
- Glaucoma
- Light Sensitivity
- Redness
- Tearing

Cardiovascular

- Angina
- Ankle Swelling
- Arrhythmias
- Arteriosclerosis
- Blood Clots
- Chest Pain
- Cold/Blue Hands, Feet
- Heart Attack
- High Blood Pressure
- Low Blood Pressure
- Noticed Heart Racing
- Pounding Sensation
- Rheumatic
- Shortness of Breath

Hair

- Colour changes
- Recent loss

Ears

- Buzzing
- Discharges
- Dizzy infection
- Ringing
- Tinnitus

Head

- Concentration
- Concussion
- Headaches
- Insomnia
- Memory decline

Mouth/Throat

- Bleeding
- Gum Disease Dental Decay
- Sore Throat
- Toothache

Gastro-intestinal

- Appendicitis
- Appetite Loss
- Black Stool
- Blood in Stool
- Colitis
- Constipation
- Crohn's Disease
- Diarrhea
- Digestive Disorders
- Gall Bladder Problem
- Gas and Bloating
- Heart Burn
- Irritable Bowel Syndrome
- Nausea
- Pain
- Pain after Eating
- Poor Appetite
- Stomach Cramps
- Stomach pain when upset
- Ulcers
- Vomiting

Urinary

- Bed Wetting
- Bladder & Kidney Infections
- Blood in Urine
- Burning
- Decreased force
- Decreased frequency
- Dribbling
- Hesitancy
- Incontinence
- Increased frequency
- Infections
- Kidney stones
- Yeast infection

Vascular

- Anemia
- Cold hands and feet
- Easy bleeding
- Easy bruising
- Hemorrhoids
- Leg pain after walking
- Raynaud's Disease
- Swelling
- Thrombophlebitis
- Varicose veins

Musculoskeletal

- Arthritis
- Back ache
- Disc problems
- Fractures
- Gout
- Hernia
- Joint pain

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- Muscle cramps
- Muscle injury
- Osteoarthritis
- Osteoporosis
- Paralysis
- Rheumatoid
- Scoliosis
- Stiffness

Neurological

- Alzheimer's
- Burning sensation
- Epilepsy
- Fainting
- Numbness
- Parkinson's
- Sciatica
- Seizures
- Tingling sensation
- Tremors

Endocrine

- Cold intolerance
- Diabetic
- Heat intolerance
- Hyperthyroid
- Hypothyroid
- Increased sweating
- Increased thirst
- Increased urine output
- Water retention

Female Reproductive

- Pregnant
  - NO
  - YES: Due date____
- Birth control pills
- Bleeding between periods
- Discharges
- Frequent periods
- HIV
- Hysterectomy
- Increased flow duration
- Increased menstrual flow
- Lumps
- Menopause
- Painful menstrual cycle
- Pelvic inflammation
- PMS
- Regular period
- STD

Male Reproductive

- Impotence
- Prostate problems
- Pus discharge
- Rashes
- STD
- Testicular pain
- Trouble with urination

Pain or Numbness

- Ankles
- Arms
- Feet
- Hands
- Hips
- Knees
- Legs
- Sciatica
- Shoulders
- Swollen joints
- Tail bone

Other Conditions

- AIDS
- Alcoholism
- Cancer
- Chemotherapy
- Depression
- Gout
- Hepatitis
- HIV Positive
- Multiple Sclerosis
- Nights sweats
- Radiation therapy
- Recent traumatic event
- Steroid therapy
- Surgery

Family History

- Arthritis
- Auto immune condition
- Cancer
- Diabetes
- Genetic problems
- Heart attack
- High blood pressure
- High cholesterol
- Hyperthyroidism
- Stroke
- Vascular problems

Childhood Conditions

- Allergies
- Asthma
- Chicken pox
- Diphtheria
- Ear infections
- Measles
- Mumps
- Rheumatic fever
- Scarlet fever
- Typhoid fever
- Whooping cough
- Other _____

Additional Information

Medications: Are you on any medications? If so please list them.

Surgeries: Have you had any previous surgeries or do you have future surgery scheduled?

Other information: Other relevant information pertaining to this case?

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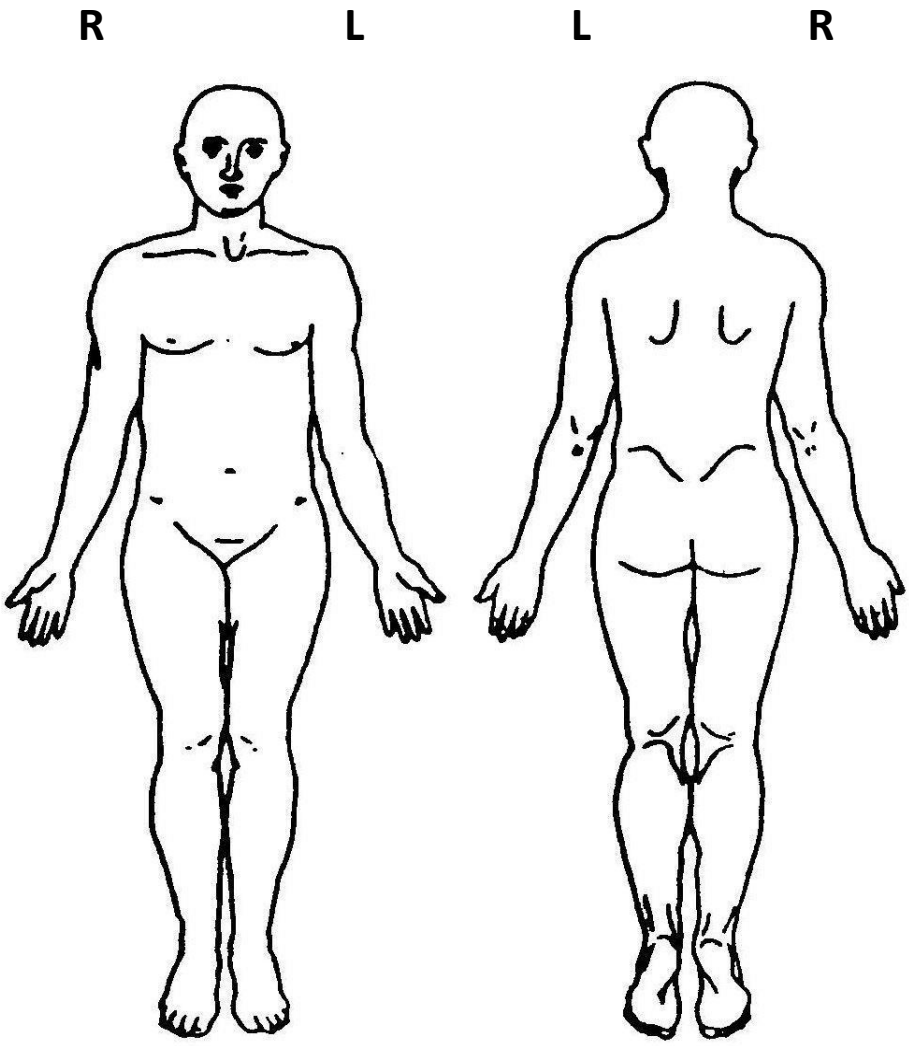
Patient Name:

Pain Diagram

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

SYMBOLS:				
Numbness	=======	Pins & Needle	;;;;;;
Burning	XXXXX	Stabbing & Sharp	/////
Dull & Aching	+++++	Stiff & Tight	222222

Pain Scale	**Amount of pain or discomfort you are experiencing**
0	No pain or discomfort
1, 2, 3	The pain or discomfort is an annoyance
4, 5, 6	The pain or discomfort interferes with activities
7, 8, 9	The pain or discomfort prevents me from performing certain activities
10	The pain or discomfort sends me to the emergency room



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