
# Patient Introduction Automobile Related Injury

Date:_____

Name: _____
First Middle Last

Address: _____

_____

_____ PC: _____

Telephone: Home:_____ Cell: _____

Work: _____

Emergency contact name and #:_____

Alberta Health Care Number: _____

Email: _____

*If you would like to subscribe to our appointment reminders, newsletters, educational and lifestyle information

Gender: Male _____ Female _____

Birth Date: Month: _____ Day: _____ Year: _____ Age: _____

Occupation: _____ Employer: _____

Marital Status: _____ Name of Spouse: _____

Ages of Children: _____

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

# Automobile Injury Consultation History

Is this work related? YES NO

Date of accident: _____ Time of accident: _____

Location of accident: _____

Road conditions at the time of accident (please circle)

WET DRY ICY OTHER _____

Did the police come to the accident scene? YES NO

Is there a report? YES NO

Was a citation issued? YES NO To whom was it issued? _____

Patient's Auto insurance company: _____

Address: _____

Phone #: _____ Claim Rep's name: _____

Policy #: _____ Claim #: _____

Driver of the other vehicle: _____ Phone #: _____

Address if known: _____

Insurance company: _____ Phone #: _____

Policy #: _____ Claim #: _____

Claim Rep's name: _____

Did you go to a hospital? YES NO

If yes, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle?

DRIVER FRONT PASSENGER BACK PASSENGER (left / right)

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?
AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO

If yes, for how long? _____

Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

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Did you become (please circle):

CONFUSED DISORIENTED LIGHTHEADED

DIZZY NAUSEATED

BLURRED VISION RING/BUZZ IN EARS

Do you still have any of these symptoms? If so, which ones? _____

_____

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Are you currently suffering from any of the following (please circle):

RESTLESSNESS IRRITABLE

DIFFICULTY CONCENTRATING DIFFICULTY WITH MEMORY

SLEEPLESSNESS FORGETFULNESS

REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

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What is the approximate distance between the back of your head and the headrest of your vehicle?

_____

Did your head go back over the top of the headrest of your vehicle? YES NO

Were you wearing a seatbelt? YES NO

If yes, what kind of seatbelt was it? LAP BELT ONLY SHOULDER-LAP BELT

Does the vehicle have an airbag? YES NO

Did the airbag deploy in this accident? YES NO

Did you receive an injury from the airbag? YES NO

If yes, please describe: _____

List the year, make and model of the vehicle you were in:

Year: _____ Make: _____ Model: _____

List the year, make and model of the OTHER CAR:

Year: _____ Make: _____ Model: _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, estimated speed of the vehicle you were in: _____ Km/hour

Did your body hit anything in the vehicle? YES NO

If yes what did you hit and with which body part? _____

Was your head pointed straightforward? YES NO

If no, which direction was it turned and by how much? _____

Was the trunk of your body pointed straight forward at the time of the collision? YES NO

If no, how was it turned and by how much? _____

Who else was in the car? _____

Please give your best description of what happened during this accident. _____

_____

_____

_____

_____

Have you been treated by another health care practitioner (MD, Physio, Massage, etc.) since the accident?
YES NO

Practitioner's name: _____

Type of practitioner: _____

Type of care received: _____

Were you having any problems before the accident? YES NO

Describe: _____

_____

Which complaints do you attribute directly to this accident? _____

_____

_____

Since the accident, are you?

STAYING THE SAME GETTING WORSE

GETTING BETTER DON'T KNOW

Have you lost time from work since the accident? YES NO

Time loss dates: _____

Type of work: _____

Are you being paid time loss of any type? YES NO

If yes, by whom? _____

Are you on work restrictions now? YES NO If yes, what type? _____

Have you ever been involved in an auto accident before? YES NO

Date(s) of accident: _____

Any difficulties from this? _____

Please list any serious injuries or illnesses in your past (including factures and hospitalizations):

_____

_____

Please list any family history of cardiovascular disease, heart disease or cancers etc….

_____

## NECK DISABILITY INDEX

**Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

**SECTION 1 - Pain Intensity**
- A I have no pain at the moment.
- B The pain is very mild at the moment.
- C The pain is moderate at the moment.
- D The pain is fairly severe at the moment.
- E The pain is very severe at the moment.
- F The pain is the worst imaginable at the moment.

**SECTION 2 - Personal Care (Washing, Dressing, etc.)**
- A I can look after myself normally without causing extra neck pain.
- B I can look after myself normally, but it causes extra pain.
- C It is painful to look after myself and I am slow and careful.
- D I need some help, but manage most of my personal care.
- E I need help every day in most aspects of self-care.
- F I do not get dressed, I wash with difficulty and stay in bed.

**SECTION 3 - Lifting**
- A I can lift heavy weights without extra neck pain.
- B I can lift heavy weights, but it gives extra pain.
- C Neck pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E I can lift only very light weights.
- F I cannot lift or carry anything at all.

**SECTION 4 - Reading**
- A I can read as much as I want with no neck pain.
- B I can read as much as I want with slight neck.
- C I can read as much as I want with moderate neck pain.
- D I cannot read as much as I want because of moderate neck pain.
- E I cannot read as much as I want because of sever neck pain.
- E I cannot read at all.

**SECTION 5 - Headaches**
- A I have no headaches at all.
- B I have slight headaches, which come infrequently.
- C I have moderate headaches, which come **in**frequently.
- D I have moderate headaches, which come frequently.
- E I have severe headaches, which come frequently.
- F I have headaches almost all the time.

**SECTION 6 - Concentration**
- A I can concentrate fully with no difficulty.
- B I can concentrate fully with slight difficulty.
- C I have a fair degree of difficulty in concentrating.
- D I have a lot of difficulty in concentrating.
- E I have a great deal of difficulty in concentrating.
- F I cannot concentrate at all.

**SECTION 7 - Work**
- A I can do as much work as I want to.
- B I can only do my usual work, but no more.
- C I can do most of my usual work, but no more.
- D I cannot do my usual work.
- E I can hardly do any work at all.
- F I cannot do any work at all.

**SECTION 8 - Driving**
- A I can drive my car without any neck pain.
- B I can drive my car as long as I want with slight pain in my neck.
- C I can drive my car as long as I want with moderate pain in my neck.
- D I cannot drive my car as long as I want because of moderate pain in my neck.
- E I can hardly drive at all because of severe pain in my neck.
- F I cannot drive my car at all.

**SECTION 9 - Sleeping**
- A I have no trouble sleeping.
- B My sleep is slightly disturbed for less than 1 hour.
- C My sleep is mildly disturbed for up to 1-2 hours.
- D My sleep is moderately disturbed for up to 2-3 hours.
- E My sleep is greatly disturbed for up to 3-5 hours.
- F My sleep is completely disturbed for up to 5-7 hours.

**SECTION 10 - Recreation**
- A I am able to engage in all of my recreational activities, with no neck pain at all.
- B I am able to engage in all of my recreational activities, with some pain in my neck.
- C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- E I can hardly do any recreational activities because of pain in my neck.
- F I cannot do any recreational activities at all.

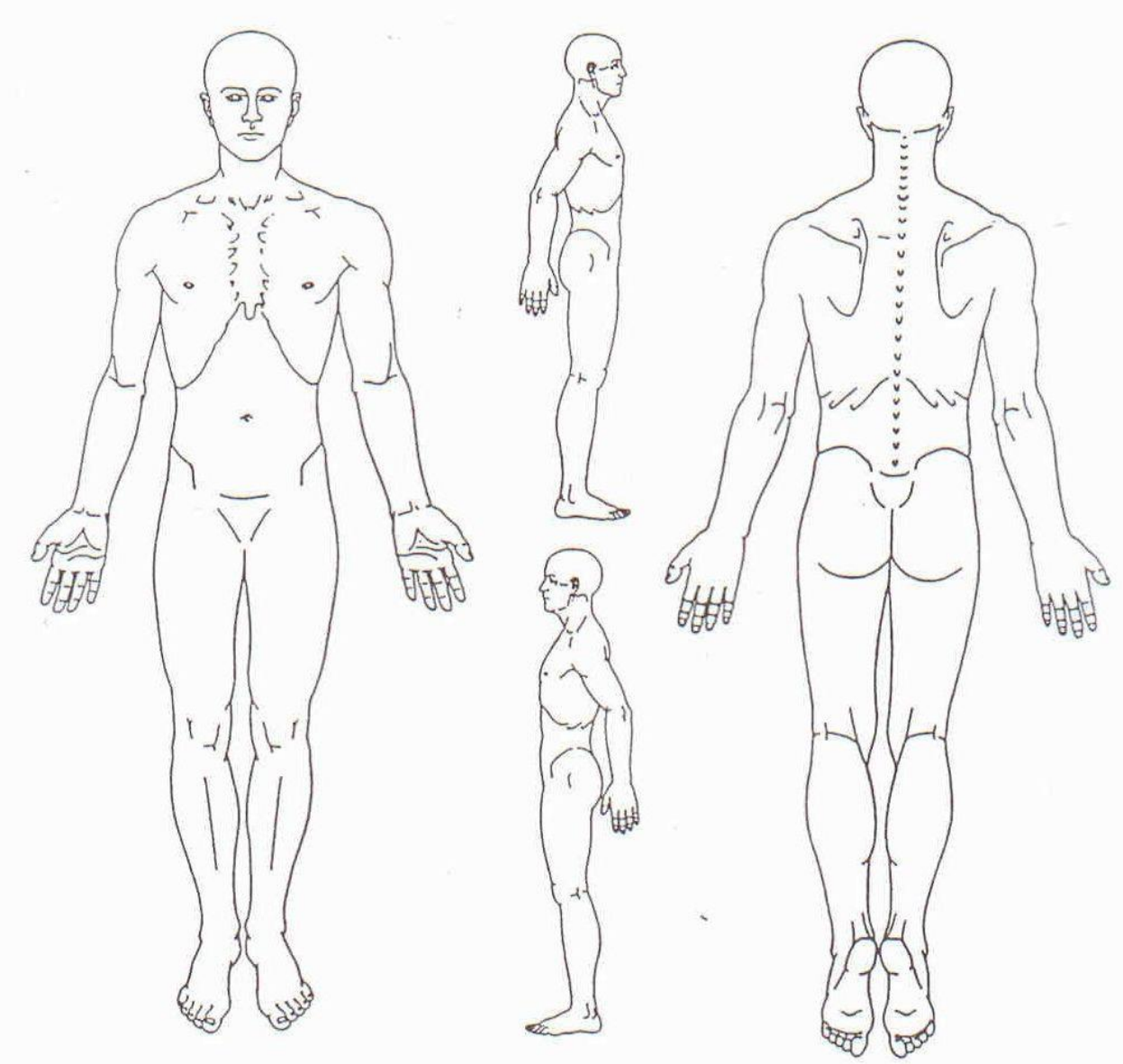
Comments: _____

## DISABILITY INDEX

NAME: _____
AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____
HOW LONG HAVE YOU HAD PAIN? _____YEARS _____MONTHS _____WEEKS
IS THIS YOUR FIRST EPISODE OF PAIN? (PLEASE CIRCLE) YES NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW.

KEY: A = ACHE B = BURNING N = NUMBNESS
P = PINS & NEEDLES S = STABBING O = OTHER



## THE REVISED OSWESTRY PAIN QUESTIONNAIRE

**Please Read: this questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

**SECTION 1 - Pain intensity**
- A The pain comes and goes and is very mild.
- B The pain is mild and does not vary much.
- C The pain comes and goes and is moderate.
- D The pain comes and goes and is severe.
- E The pain is severe and does not vary much.

**SECTION 2 - Personal Care**
- A I would not have to change my way of washing or dressing in order to avoid pain.
- B I do not normally change my way of washing or dressing even though it causes some pain.
- C Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D Because of the pain, I am unable to do some washing and dressing without help.
- E Because of the pain, I am unable to do some washing and dressing without help.
- F Because of the pain, I am unable to do any washing or dressing without help.

**SECTION 3 - Lifting**
- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it causes extra pain.
- C Pain prevents me from lifting heavy weights off the floor.
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F I can only lift very light weights, at the most.

**SECTION 4 - Walking**
- A Pain does not prevent me from walking any distance.
- B Pain prevents me from walking more than one mile.
- C Pain prevents me from walking more than ½ mile.
- D Pain prevents me from walking more than ¼ mile.
- E I can only walk while using a cane or on crutches.
- F I am in bed most of the time and have to crawl to the toilet.

**SECTION 5 - Sitting**
- A I can sit in any chair as long as I like without pain.
- B I can only sit in my favourite chair as long as I like.
- C Pain prevents me from sitting more than one hour.
- D Pain prevents me from sitting more than ½ hour.
- E Pain prevents me from sitting more than 10 minutes.
- F Pain prevents me from sitting at all.

Comments: _____

_____

_____

_____

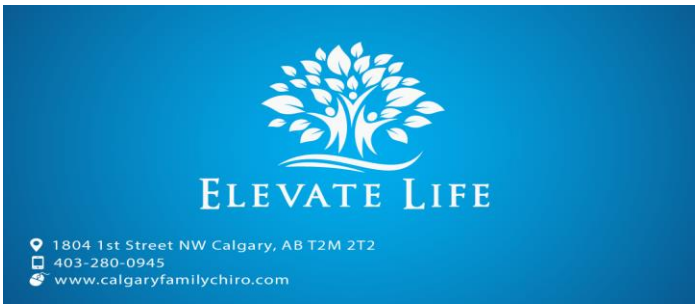
**SECTION 6 - Standing**
- A I can stand as long as I want without pain.
- B I have some pain while standing, but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than ½ hour without increasing pain.
- E I cannot stand for longer than 10 minutes without increasing pain.
- F I avoid standing, because it increases the pain straight away.

**SECTION 7 - Sleeping**
- A I get no pain in bed.
- B I get pain in bed, but it does not prevent me from sleeping well.
- C Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D Because of pain, my normal night's sleep is reduced by less than one-half.
- E Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F Pain prevents me from sleeping at all.

**SECTION 8 - Social Life**
- A My social life is normal and gives me no pain.
- B My social life is normal, but increases the degree of my pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D Pain has restricted my social life and I do not go out very often.
- E Pain has restricted my social life to my home.
- F I have hardly any social life because of the pain.

**SECTION 9 - Traveling**
- A I get no pain while traveling.
- B I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D I get extra pain while traveling which compels me to seek alternative forms of travel.
- E Pain restricts all forms of travel.
- F Pain prevents all forms of travel except that done lying down.

**SECTION 10 - Changing Degree of Pain**
- A My pain is rapidly getting better.
- B My pain fluctuates, but overall is definitely getting better.
- C My pain seems to be getting better, but improvement is slow at present.
- D My pain is neither getting better nor worse.
- E My pain is gradually worsening.
- F My pain is rapidly worsening.




## MEDIA RELEASE CONSENT

Purpose of Consent: By signing this form, you are consenting to allow **ELEVATE LIFE CHIROPRACTIC CLINIC** and any associated staff members to use and distribute your photo along with your patient testimonial. To use and disclose the information you provided in your video consent. Also acknowledge that your testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to us. Please understand that revocation of this Release will not affect any action **ELEVATE LIFE CHIROPRACTIC CLINIC** or his/her staff took in reliance on this Release before receiving your revocation.

I hereby grant permission to allow **ELEVATE LIFE CHIROPRACTIC CLINIC** to use the photograph of me shown below in conjunction with my patient testimonial. I hereby agree and acknowledge that my photo will be released to the public via public relation efforts of **ELEVATE LIFE CHIROPRACTIC CLINIC** I further acknowledge and agree that my photo, video, or testimonial may be used by the media.

I waive the right of prior approval and hereby release **ELEVATE LIFE CHIROPRACTIC CLINIC** from any and all claims for damages of any kind based on the use of my photo,video or information contained in my testimonial.

By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

_____

Signature and/or Legal Guardian Date

_____

**Print Name**

**I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. _____ (Initials)**

**I further understand that interest of 2% per month calculated monthly (24% per year compounded monthly) would be charged to any unpaid balance. I agree to pay this interest on any unpaid balance. I further agree to pay for any charges or fees (collection charges or legal fees) incurred in the collection of this account, should that become necessary. _____ (Initials)**

# 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 <u>NOT</u> 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

*Thank You!*