



INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) herby consent to the performance of examination and treatment on me, by the licensed Doctor of Chiropractic, Medical Doctor, Physiotherapist, Occupational Therapist, Registered Sonographer, Registered Massage Therapist, Masseuse, Doctor of Traditional Chinese Medicine, Registered Acupuncturist, Registered Dietitian, Registered Kinesiologist, and Registered Clinical Counsellor that may be employed by or engaged in practice at this clinic.

I understand that my care may involve judgment based upon facts and information known to the Practitioner. The Practitioner uses this judgment to attempt to anticipate or explain risks and complications, and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but I wish to rely on the Practitioners to choose and recommend the best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with the above Practitioner's treatments, which includes rarely, but not limited to fractures, disc injuries, strokes, and strains/sprains. I am therefore willing to accept and consent to the possible risks associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Cancellation Policy: Your appointment has been reserved for you. As a courtesy to your therapist and other patients we ask that you arrive on time and provide us with at least 24 hours notice of cancellation. It is at the discretion of your therapist to charge you for missed appointments and canceled appointments without giving 24 hours notice. Thank you for your cooperation.

For ICBC Clients Only: I _____, authorize Mountainview Kinesiology Ltd. to obtain and/or release information regarding my diagnosis, treatment progress, functional abilities and return to work/activity to ICBC, as per Sec 28 and Sec 28.1 of the Insurance (Vehicle) Act.

Signature: _____

By signing below you have read and understood the above consent to treatment and cancellation policy.

Patient Name (Print)

Witness Name (Print)

Patient Signature

Witness Signature

Date

Date

Welcome to Mountainview Kinesiology

| | | | | |
|--|---------------|-----------------|---------------------------------------|----------------------------------|
| Full Name: (as it appears on your Care Card) | | | | |
| Former Name/Preferred Name (if applic.): | | | | |
| Date of Birth (DD/MM/YYYY): | | | | |
| Care Card Number: | | | | |
| Street Address (Apt. # if applic.): | | | | |
| City/Province: | | | Postal Code: | |
| Home Phone: | | | Cell Phone: | |
| Occupation: | | | | |
| Work Phone: | | | | |
| Email: | | | | |
| Emergency Contact Name: | | | Emergency Contact Number: | |
| Physician's Name: | | | Physician's Number: | |
| Other Health Care Providers: | | | Other Health Care Providers' Numbers: | |
| How did you hear about our clinic? | | | | |
| Please enter specific details (name of friend, doctor, event, etc.): | | | | |
| Type of treatment you are seeking? (Check all that apply) | | | | |
| Chiropractic | Physiotherapy | Massage Therapy | Acupuncture | Dietetics/Nutritional Counseling |
| TCM | Kinesiology | Psychology | Osteopathic | Occupational Therapy |
| Previous treatment(s) for this condition: | | | | |

| | | | | |
|---|--------------|----------|-------------------|--------------------|
| Have you, or will you be submitting a claim to: | ICBC: | Accepted | Pending | Have Legal Counsel |
| | WorkSafe BC: | Accepted | Pending | Have Legal Counsel |
| Claim Number (specific to this injury): | | | Adjuster's Name: | |
| Date of Injury/Accident: | | | Adjuster's Phone: | |

Please describe the nature of your injury (i.e. location, symptoms, impact on activities of daily living or sport participation, etc.)

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

- | | | |
|--------------------------------------|----------------------------------|-----------------------------------|
| Abdominal Problems | Dislocations | Numbness or Tingling |
| Arthritis | Dizziness | Polio/Post-Polio Syndrome |
| Asthma | Fractures | Psychiatric or Psychological Care |
| Artificial Joint | Gastrointestinal Disorder | Recent Weight Loss or Gain |
| Balance Problems | High/Low Blood Pressure | Respiratory Condition |
| Blurred or Double Vision | Headaches | Seizures |
| Cancer /History of/Family History of | Heart Disease /Family History of | Shortness of Breath |
| Chest Pain | Herniated Disc | Skin Condition |
| Concussion | Hot or Cold Intolerance | Sleep Disorder |
| Currently Pregnant | Nausea/Vomiting | Stroke |
| Diabetes | Neurological Disorder | Ulcers |
| Difficulty Swallowing/Eating | Osteoporosis/Low Bone Density | Vascular Disease |
| Other: | | |

Please list all surgeries and/or significant injuries/accidents (with approximate date):

Please list all medications and/or supplements currently being taken:

Are you currently a smoker? YES NO If yes, how many cigarettes per day?: _____

Have you smoked in the past? YES NO



PHYSIOTHERAPY
MASSAGE THERAPY
ACUPUNCTURE

CHIROPRACTIC
DIETETICS
AND MORE

Please list any illnesses or conditions that run in your immediate family:

Mountainview Kinesiology offers **Complimentary Consultations** for all of the different services provided at the clinic. Check if you are interested in booking a Complimentary Consultation (check all that apply):

| | | | | | |
|---------------|--------------|-----------------|-------------|-----------|-------------|
| Physiotherapy | Chiropractic | Massage Therapy | Acupuncture | Dietitian | Kinesiology |
| TCM | Psychology | Counselling | Osteopathic | | |

CANCELLATION POLICY

The time of your appointment has been specifically set aside for you. We require 24 hours notice for cancellation of an appointment. You will be charged the entire visit fee for a missed appointment or short-notice cancellation. As a courtesy to you, we are willing to change appointment times to better suit your needs with adequate notice, or in the event of an emergency.

The above information is true to the best of my knowledge. I consent to the sharing of my records between practitioners of Mountainview Kinesiology as well as with my medical doctor and outside healthcare practitioners in order to integrate and facilitate my care. I consent to receiving voice messages and email reminders about my upcoming appointments or my care at Mountainview Kinesiology.

I consent to receiving occasional contact from Mountainview Kinesiology by email (quarterly newsletter, important policy changes, etc.).

Patient's Signature: _____

Date: _____

Parent's Signature:
(if patient is under 18 yrs) _____

Date: _____