VELOCITY

Today's Date:

PATIENT INFORMATION (Please Show Health Card to Receptionist)

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	First Name	Middle Initial	Last Name	Marital Status: ☐ Sgl ☐ Mar
Birth Date (MM/DD/YR)		Age	Health Card Number (& Version Code)	
Street Address		City	Province	Postal Code
Home Telephone	Work Telephone	Cell Phone	Email Address	
Family Physician	Physician Telephone	Emergency Contact (Name/Relation/Tel#)	Occupation	

ATHLETE INFORMATION:

Sport	Team Name	Division/Level	Age Group
Coaches Name & Contact			CSCO Number

INSURANCE CLAIMS

☐ MVA	Date of Accident	Claim Number/Policy Number	Company Claims Manager Name and Contact
☐ WSIB	SIN	Employers Name and Address	Do you have any private insurance? Company Name

HOW DID YOU HEAR ABOUT US?

☐ Website- Search Engine ☐ Drive By/Walk-In ☐ Flyer ☐ On-Site Medical Event ☐ Running Room or Runner's Mark talk _____

☐ Friend ☐ Coach ☐ Relative. If you were referred by someone in particular please let us know, so we can thank them for their support. _____

☐ Advertisement: _____

Health History

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries or other Hospitalizations:

Year:	Reason:	Year	Reason:

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

HEALTH HABITS AND PERSONAL SAFETY

☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

OTHER PROBLEMS

☐ Skin ☐ Head/Neck ☐ Ears ☐ Nose ☐ Throat ☐ Lungs ☐ Chest/Heart	☐ Back ☐ Intestines ☐ Bladder ☐ Bowels ☐ Circulation	**Recent Changes In:** ☐ Weight ☐ Energy Level ☐ Ability to Sleep **Other Pain/Discomfort:**

Privacy Code

Privacy of personal information is important to Velocity Sports Medicine & Rehabilitation. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be as open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; the health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinics understand the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes
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Please do not hesitate to discuss our privacy policy with any member of our clinic staff.
By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent

I have reviewed the above information that explains how our clinics will use my personal information
I agree that Velocity Sports Medicine & Rehabilitation can collect, use and disclosure my personal information as set out above in the College's privacy code.

_____	_____	_____	_____
(Signature)	(Print name)	(Date)	(witness)

VELOCITY
Sports Medicine & Rehabilitation

Patient Name (please print): _____

INFORMED CONSENT TO PHYSIOTHERAPY AND ATHLETIC THERAPY TREATMENT

Doctors of chiropractic, medical doctors, and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments

b. There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause strokes, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote;

c. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries caused or may be caused, by spinal adjustments or chiropractic treatment

Physiotherapy treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Physiotherapy care contributes to your overall well being. The risk of injuries or complications from physiotherapy treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my physiotherapist the nature and purpose of physiotherapy treatment in general and my treatment in particular as well as the contents of this Consent.

I consent to the physiotherapy treatments offered or recommended to me by my physiotherapist, including spinal adjustment. I intend this consent to apply to all my present and future physiotherapy care.

_____ **Date:**_____ _____ **Date:** _____

Patient Signature (Legal Guardian) **Witness of Signature**

INFORMED CONSENT FOR ACUPUNCTURE

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, moxabustion, cupping, guasha, laser, electoacupunture, and other techniques within the scope of practice of acupuncturists. These procedures may be performed by the acupuncturists or another duly authorized person in the clinic.

I have had the opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and an informed that, as with all health care, the practice of acupuncture possess slight risks from treatment, including but not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection, and shock. I do not expect acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedures which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above named procedure(s). I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ **Date:**_____ _____ **Date:** _____

Patient Signature (Legal Guardian) **Witness of Signature**