Mountainview
HEALTH & WELLNESS

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 cancelled appointments without giving 24 hours notice. Thank you for your cooperation.

For ICBC Clients Only: I _____, authorize Mountainview Health and Wellness 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

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PHYSIOTHERAPY
MASSAGE THERAPY
ACUPUNCTURE
CHIROPRACTIC
DIETETICS
AND MORE

Welcome to Mountainview Health & Wellness

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

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

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

Mountainview Health & Wellness 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 Health & Wellness 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 Health & Wellness.

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

Patient's Signature: _____ Date: _____

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