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

PHYSIOTHERAPY | CHIROPRACTIC
MASSAGE THERAPY | DIETETICS
ACUPUNCTURE | AND MORE

WCB Initial Questionnaire

Worker Information		
Last Name:	First Name:	Middle Initial:
Date of initial visit (dd/mm/yyyy):	Care Card No.:	

Claim Information	
Claim Number:	Date of injury (dd/mm/yyyy):
Area(s) of injury accepted on this claim:	
Claim Manager:	Claim Manager's Phone No.:
Attending Doctor:	Attending Doctor's Phone No.:

Injury Information
When did you first get examined?
Who examined you (family doctor, hospital, etc.)?
Describe how you were injured:
Were there any x-rays taken (or other imaging)? ☐Yes ☐No

Employer and Job Information	
Occupation:	Company Name:
Worksite Address:	
City/Province:	Postal Code:
Company Phone No.:	Company Fax No.:
Contact Name:	Contact Job Title:
Contact Phone No.:	
Pre-Injury job attachment status: ☐Job attached ☐Job not attached ☐Not yet confirmed	
Usual pre-injury work schedule: Days per week: Hours per day: Additional info:	
Are you currently working? ☐Yes ☐No	Are light modified duties available? ☐Yes ☐No
Please describe your job and your work duties:	

Employer and Job Information (continued)	
For the specific demands listed below, please check the box that applies to your job requirements as well as your current capabilities:	
Walking:	Required: ☐ Short Distance ☐ Prolonged Comments: Capability: ☐ Short Distance ☐ Prolonged
Standing:	Required: ☐ 0-15 min ☐ 15-30 min ☐ 30+ min Frequency/Comments: Capability: ☐ 0-15 min ☐ 15-30 min ☐ 30+ min Comments:
Sitting:	Required: ☐ 0-30 min ☐ 30-60 min ☐ 60+ min Frequency/Comments: Capability: ☐ 0-30 min ☐ 30-60 min ☐ 60+ min Comments:
Lifting Below Shoulder Height:	Required: ☐ 0-10 kg ☐ 10-25 kg ☐ 25+ kg Frequency/Comments: Capability: ☐ 0-10 kg ☐ 10-25 kg ☐ 25+ kg Comments:
Lifting Above Shoulder Height:	Required: ☐ 0-10 kg ☐ 10-25 kg ☐ 25+ kg Frequency/Comments: Capability: ☐ 0-10 kg ☐ 10-25 kg ☐ 25+ kg Comments:
Stair Climbing:	Required: ☐ None ☐ 2-3 steps ☐ Short Flight ☐ Multiple Flights ☐ Carrying Loads Capability: ☐ None ☐ 2-3 steps ☐ Short Flight ☐ Multiple Flights ☐ Carrying Loads
Ladder Climbing:	Required: ☐ None ☐ 2-3 steps ☐ 4-6 steps ☐ Long Ladders ☐ Carrying Loads Capability: ☐ None ☐ 2-3 steps ☐ 4-6 steps ☐ Long Ladders ☐ Carrying Loads
Bending Forward:	Required: ☐ Yes ☐ No Duration/Comments: Capability: ☐ Yes ☐ No Comments:
Squatting/Kneeling:	Required: ☐ Yes ☐ No Duration/Comments: Capability: ☐ Yes ☐ No Comments:
Repetitive Movements:	Required: ☐ Yes ☐ No Duration/Comments: Capability: ☐ Yes ☐ No Comments:

Statement of Understanding

I understand that Mountainview Health & Wellness has a 24-hour cancellation policy and that I will be charged the **full private cost** for a missed appointment or a short notice cancellation.

Signature: ____