Noji CHIROPRACTIC & WELLNESS CENTRE
115 Stafford Drive S., Lethbridge, AB T1J 4N8
Phone (403)381-7766 www.nojichiropractic.com

CONSULTATION ADMITTANCE FORM

Last Name:_____ First Name:_____
Address:_____ City:_____ Postal Code:_____
Home Phone:_____ Work:_____ Cell:_____ Provider:_____
Age:_____ Birth Date (dd/mm/yr):_____ Sex: M / F Height_____ Weight_____
Occupation:_____ Alberta Health Care #_____
Referred by:_____ e-mail:_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

Reason for appointment? _____
When did your condition begin? _____
Previous head or neck injuries? _____
Have you ever had similar problems: ☐ Yes ☐ No
Have you had X-Rays, MRI or other tests for this condition? What tests and when?_____
_____
Is this condition related to: Work? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐No
Motor Vehicle Accident? ☐ Yes ☐ No Date of Injury: _____
Since your condition, what are your limitations? _____

Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Can you perform your daily work activities?	☐ All activities	☐ Only some	☐ Not at all
Describe your stress level?	☐ None ☐ Mild	☐ Moderate	☐ High
Do you exercise?	☐ Daily	☐ Occasionally	☐ Not at all

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):_____
_____
_____
Have you had previous chiropractic care? ☐ Yes ☐ No Doctor:_____ Date:_____
Family Doctor name: _____
List ALL medications (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.)
_____
_____
Emergency contact name: _____ Phone # _____

Date: _____ Patient Signature: _____

*** Our office will confirm all appointments by either text message or e-mail, please circle your preference.**

Systems Review ***Patient Name*** _____ ***Date*** _____

Please ***circle*** any conditions that are ***presently*** causing you a problem and **underline** those that have caused you problems in the **past.**

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Pain over heart	Ulcers
Headache	Hardening of arteries	Nausea
Numbness	Swollen ankles	Vomiting
Neuralgia (nerve pain)	Poor circulation	Constipation
Poor coordination	Palpitations	Diarrhea
Weakness	Cold hands or feet	Blood in stool
	Varicose veins	Gallbladder/Jaundice
		Colitis
EENT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/Numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders	Birth control pills
Enlarged glands	Swollen joints	Miscarriages
	Spinal Curvature	Complications with pregnancy
	Arthritis	Are you pregnant? Yes No
	Fractures	If yes, week_____
		Date of last menstrual cycle?
		_____

FAMILY MEDICAL HEALTH INFORMATION

MANY HEALTH PROBLEMS ARE THE RESULT OF HEREDITARY SPINAL WEAKNESSES. THIS INFORMATION ABOUT YOUR FAMILY MEMBERS WILL GIVE US A BETTER PICTURE OF YOUR TOTAL HEALTH.

Have you or a family member a history of the following:

Aids	**Alcoholism**	**Allergies**	**Arthritis**	**Asthma**
Bed Wetting	**Cancer**	**Cardiovascular Disease**	**Depression**	**Diabetes**
Epilepsy	**Hyperactivity**	**Learning Disability**	**Lumbago**	**Multiple Sclerosis**
Schizophrenia	**Stomach Ulcers**	**Venereal Disease**	**Other**_____	

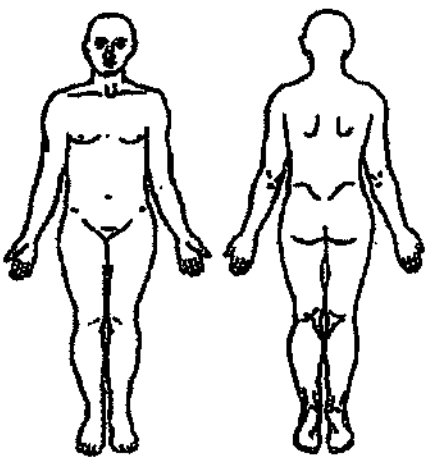
HEALTH HISTORY QUESTIONNAIRE

Name: _____

Have you ever been diagnosed or told you have any of the following?
Please circle the correct response

1. High blood pressure.....	Yes	No
2. Hardening of the arteries (arteriosclerosis).....	Yes	No
3. Diabetes.....	Yes	No
4. Tuberculosis.....	Yes	No
5. Cancer, where?.....	Yes	No
6. Heart or Blood diseases.....	Yes	No
7. Bone spurs on the neck bones (cervical sprain).....	Yes	No
8. Whiplash injury (flexion-extension injury, cervical sprain).....	Yes	No
9. Have you or any of your relatives ever suffered a stroke?.....	Yes	No
10. Were you ever a smoker? From_____ To_____	Yes	No
11. Do you take any medication on a regular basis?.....	Yes	No
12. Visual disturbances (blurring, loss, double).....	Yes	No
13. Hearing disturbances (loss, ringing, other noise).....	Yes	No
14. Slurred speech or other speech problems.....	Yes	No
15. Difficulty swallowing.....	Yes	No
16. Dizziness.....	Yes	No
17. Loss of consciousness, even momentary blackouts.....	Yes	No
18. Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs or any other parts of the body.....	Yes	No
19. Sudden collapse without loss of consciousness.....	Yes	No

Indicate the location of your pain by shading in the appropriate area



Indicate the severity of the pain by circling a number

No pain | 0 1 2 3 4 5 6 7 8 9 10 | Extreme Pain

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____ _____
Signature Date

115 Stafford Drive South
Lethbridge, AB
T1J 4N8

Noji CHIROPRACTIC & WELLNESS CENTRE

Bus: 403-381-7766
Fax: 403-320-0082

Dr. Janice L. Noji, D.C.*
Dr. Matthew Noji, D.C.*
Dr. Benjamin Noji, D.C.*

Informed Consent to Assessments & Laser Therapy

I hereby request and consent to the performance of assessments, laser therapy, various modes of physical therapy, and any other procedures, on me by the practitioners listed at this clinic and or anyone working at this clinic authorized by the practitioners.

I have had the opportunity to discuss with the practitioners listed at this clinic, the nature and purpose of assessments, laser therapy, various modes of physical therapy, and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of laser therapy, there are some risks, including but not limited to short term aggravation of symptoms. When used in combination with certain medications laser therapy can cause burns and I therefore understand that I must disclose all information on my current medications to the practitioners at this clinic. I also understand that laser can cause damage to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic, must be worn by me during laser treatments.

I also understand that I may not be a candidate for laser therapy if I have been diagnosed with cancer in the last 5 years or if I have an active infection and will therefore disclose this information to the practitioners at this clinic.

I do not expect the practitioners listed at this clinic to be able to indicate or explain all risks and complications and I wish to rely on the exercise of judgement during the course of assessment and/or procedures which the practitioners feel at the time, based upon the facts known, is in my best interest.

I acknowledge I have discussed, or have had the opportunity to discuss, with my practitioner or anyone working in this clinic authorized by my practitioner, the nature and purpose of my treatments as well as the content of this consent.

I consent to the assessments, performance of laser therapy and various modes of physical therapy, including but not limited to chiropractic and laser therapy, offered or recommended to me by the practitioners in this clinic. I intend this consent to apply to all my present and future care in this clinic.

Dated this _____ day of _____, 20 ____

Patient / Guardian Signature

_____

Name of Patient

_____

Witness Signature

_____

Name of Witness

_____

Clinic Practitioner's as of above signed date: _____

***There will be a fee of 50% of the service cost for any appointment missed or not cancelled within 24 hours.**

Noji Chiropractic & Wellness Centre
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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits
Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks
The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy
The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives
Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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.**

THERE WILL BE A FEE OF 50% OF THE SERVICE COST FOR ANY APPOINTMENT MISSED OR NOT CANCELLED WITHIN 24 HOURS

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have read this form and 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 acupuncture treatment as proposed to me.

Please note that all treatments are billed under Chiropractic insurance.

Name (Please Print)	Signature of Patient (or legal guardian)	Date
Signature of Chiropractor		Date

NOJI FAMILY
CHIROPRACTIC & WELLNESS CENTRE

EXTRA-CORPOREAL SHOCKWAVE THERAPY CONSENT FROM

What is extracorporeal radical shockwave therapy?

Extracorporeal Shockwave Therapy is a series of high-energy percussions to the affected area. The shockwave is a physical sound wave "shock", not an electric one.

How does it work?

1) Treatment produces an inflammatory response. The body responds by increasing metabolic activity around the site of pain. This stimulates and accelerates the healing process, promotes the remodelling of dysfunctional collagenous tissues, such as a tendinopathies, trigger points, muscle strains, etc.
2) Shockwaves break down scar tissues and/or calcification

What are the benefits of Shockwave Treatments?

This therapy stimulates the body's natural self-healing process. There is actually an immediate reduction of pain and improved range of motion. ESWT may also eliminate your need for surgery.

How long does the treatment last?

Approximately 2000 shocks are administered per treatment area (the duration of which is approximately 5 minutes). Some patients and/or conditions require more shock and duration, depending on severity and chronicity (how long the condition or injury has existed).

How many treatments will I need?

Normally three to six treatments are necessary at weekly intervals; there is a possibility that six to eight treatments may be necessary if your condition is very chronic. Should you not respond in this time, your case will be reviewed with the doctor to determine an appropriate referral. Success rates with ESWT are unparalleled (over 80-90% improvement).

Does the treatment hurt?

It is a short treatment (usually 15 to 20 minutes) that may be fairly uncomfortable. However, most people are able to easily tolerate it. However, if you cannot tolerate it, adjustments on the machine can decrease the pressure you feel.

Will it hurt after the treatment?

There may or may not be immediate pain, but discomfort may be experienced 2-4 hours after the treatment. In some cases it can last up to 48 hours and in very rare cases, the pain lasted up to 5 rays. Some bruising and swelling can occur.

What should I do if I am in pain after the treatment?

The shockwave will trigger an inflammatory response, which is the body's natural process of healing. For this

reason, do not use anti-inflammatory medications. Do not use ice. The pain should subside within 24 hours. Use Tylenol if necessary, provided you have no trouble with this medication.

What if it feels good after the treatment?

Even if it feels good, we recommended decreased activity for 48 hours following treatment.

Is Shockwave Therapy covered by my insurance?

If you have insurance you will want to ask your provider about the requirements of your coverage. You will be involved under Chiropractic/Extracorporeal Shockwave Therapy treatment.

What is the success rate of this kind of treatment?

A successful treatment is considered as a patient having at least 75% reduction in pain within 3 months. Worldwide, success rates are around 80-90%.

What if it doesn't work for me?

Although the short-term effects alone are exceptional, the long-term benefits of this treatment may take up to 3-4 months. If after this time there has not been any marked improvement, you should see your doctor for further treatment options.

Are there contraindications and/or precautions? Contraindications include:

- Coagulation disorders, thrombosis, heart or circulatory patients
- Use of anticoagulants, especially Marcumar, Heparin, Coumadin
- Tumor diseases, carcinoma, cancer patients
- Pregnancy
- Polyneuropathy in case of diabetes mellitus
- Acute inflammation / pus focus in the target area
- Children in growth
- Cortisone therapy up to 6 weeks before first treatment

Side Effects include: (These side effects generally abate after 5 to 10 days.)

- Swelling, reddening, haematomas
- Petechiae, bruising
- Pain
- Skin lesions (especially after previous cortisone therapy)

Why am I asked to sign a consent from?

Pain can increase temporarily. Bruising and swelling are also possible. We want you to be informed of all aspects. By signing the below, you acknowledge that you understand and accept risks, benefits and cost of shockwave therapy, and consent to having this therapy administered.

THERE WILL BE A FEE OF 50% OF THE SERVICE COST FOR ANY APPOINTMENT MISSED OR NOT CANCELLED WITHIN 24 HOURS

Name: _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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