Date: _____

Patient Name: _____ Date of Birth : _____

Address: _____

City: _____ Province: _____ Postal Code:_____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Work Phone: _____

Marital Status: Single Married Divorced Separated Widowed Spouse's Name: _____

Children (Names and Ages) _____

Your Occupation: _____ Employer: _____

Work Address: _____

City: _____ Province: _____ Postal Code:_____

Emergency Contact: _____ Phone Number: _____

How did you hear about our office? _____

Will this claim be made against:

1. Recent motor vehicle accident? ☐ Yes ☐ No
2. Work related injury/accident? ☐ Yes ☐ No

Prior Chiropractic Care:

Name: _____ Phone Number: _____

X-Rays Taken? ☐ Yes ☐ No Date: _____

Results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Please Explain: _____

Medical Doctor:

Name: _____ Phone Number: _____

Address: _____

Date of Last Appointment: _____ Date of Last Physical: _____

Reason for Consulting This Office:

Health concern: _____

When did you notice it? _____ How often does it occur? _____

Does it radiate? ☐ Yes ☐ No If Yes, where? _____

What relieves it? _____

What aggravates it? _____

Describe how it interferes with your life, work or hobbies. _____

_____

What have you tried to get rid of the problem that did not work? _____

If you are experiencing pain, is it:

☐ Sharp ☐ Dull ☐ Comes & Goes ☐ Constant ☐ Travels

Since the problem started, is it: ☐ About the Same ☐ Getting Better ☐ Getting Worse

Other professionals seen for this concern: _____

Treatment and Results: _____

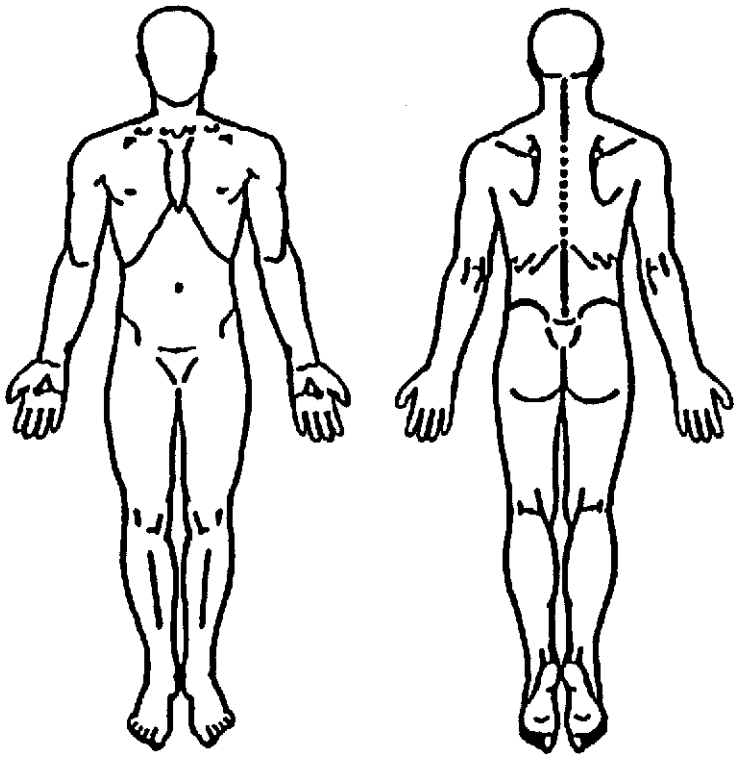
What are your expectations on your 1st visit here? _____

Rate your commitment to getting rid of this problem, 10 being highest: 1 2 3 4 5 6 7 8 9 10

Are there any current or previous x-ray, CT, or MRI studies related to this area? What are the results?

_____

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.



Numbness ● ● ● ● ●
● ● ● ● ●
● ● ● ● ●

Pins & Needles ○ ○ ○ ○ ○
○ ○ ○ ○ ○
○ ○ ○ ○ ○

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /

Habits of Lifestyle

Do you smoke? ☐ Yes ☐ No Packs / day _____

Do you consume alcohol? ☐ Yes ☐ No Drinks / day _____

Do you exercise? ☐ Yes ☐ No Hours / day _____

Rate your sleep hours per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+

Is your bed comfortable? ☐ Yes ☐ No Type of bed: _____

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat per day: ☐ 1 meal ☐ 2 meals ☐ 3 meals ☐ 4 meals ☐ More than 4 meals

Past Medical History

Please check any symptoms you are currently experiencing or have experienced in the past

Now	Past		Now	Past		Now	Past	
☐	☐	Low Back Pain	☐	☐	Paralysis	☐	☐	Constipation
☐	☐	Pain between the shoulders	☐	☐	Dizziness	☐	☐	Weight trouble
☐	☐	Neck pain	☐	☐	Fainting	☐	☐	Abdominal cramps
☐	☐	Joint pain / stiffness	☐	☐	Cold / tingling extremities	☐	☐	Gas / bloating
☐	☐	Arm pain	☐	☐	Stress	☐	☐	Heart burn
☐	☐	Difficult chewing / clicking jaw	☐	☐	Headaches	☐	☐	Colitis
☐	☐	General stiffness	☐	☐	Gall Bladder problems	☐	☐	Hemorrhoids
☐	☐	Numbness	☐	☐	Liver problems	☐	☐	Bladder troubles
☐	☐	Walking problems	☐	☐	Allergies	☐	☐	Painful urination
☐	☐	Nervousness	☐	☐	Loss of Sleep	☐	☐	Chest pain
☐	☐	Forgetfulness	☐	☐	Excessive Thirst	☐	☐	Shortness of breath
☐	☐	Confusion / Depression	☐	☐	Frequent Nausea	☐	☐	Blood Pressure
☐	☐	Convulsions	☐	☐	Vomiting	☐	☐	Irregular heartbeat
☐	☐	Fatigue	☐	☐	Diarrhea	☐	☐	Heart problems
☐	☐	Varicose veins	☐	☐	Diabetes	☐	☐	Lung congestion
☐	☐	Ankle swelling	☐	☐	Vision problems	☐	☐	Lung problems
☐	☐	Stroke	☐	☐	Dental problems	☐	☐	Sexual Dysfunction
☐	☐	Arthritis	☐	☐	Sore throat	☐	☐	Menstrual pain
☐	☐	Sinus congestion	☐	☐	Ear Aches	☐	☐	Other _____
☐	☐	Stuffed nose	☐	☐	Hearing difficulty	☐	☐	Other _____

Falls, accidents, strains/sprains or broken bones (please list):

_____

_____

Surgery/ Operations (please list):

_____

_____

Surgery recommended but not performed (please list):

_____

_____

Do you take any vitamins? ☐ Yes ☐ No **List:** _____

List any medication or drugs you are currently taking: _____

_____

Have you previously been hospitalized? ☐ Yes ☐ No

Please List: _____

_____

_____

Family Health Profile

At our office we are not only interested in your health and well being, but also the health and well being of your family, loved ones and our community. Please mention below any health conditions or concerns pertaining to your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother (s): _____

Sister(s):_____

EXTENDED HEALTH CARE

Do you have Extended Health Care? ☐ Yes ☐ No

If yes, please answer the following:

Is chiropractic coverage: a) Per visit _____ max/visit

b) Total maximum _____

Massage coverage: a) Per visit _____ max/visit

b) Total maximum _____

Orthotic coverage: a) Allowed amount_____

b) Every year _____, Every _____ years

Naturopathy a) Per visit _____ max/visit

b) Total maximum _____

Policy Holder Name: _____

Company Name: _____ Phone: _____

Our Financial Policies

Please check with your insurance company regarding your benefits. In order to be reimbursed by your insurance company, please ask our staff to print an Extended Health Care Financial Record, which must be submitted with your claim to your company. However, we do require payment for services rendered on the day of your appointment. We cannot guarantee that your insurance company will make payment for the same.

It is the policy of the Canadian Disc Institute that payment arrangements are made prior to treatment commencing.

We accept cheques, Debit, Visa, Mastercard and cash. If you are going to be on a regular treatment plan of one or more months, it is possible a payment plan may be worked out for you.

FEE SCHEDULE

Adult	Total
Initial Consultation/Examination	195.00
Radiographic (x-rays) – per view	50.00
Thermographic and EMG Scans – per scan	45.00
Report of Findings (1 hr. - additional billed at hourly rate)	100.00
Chiropractic Adjustment	80.00
Comparative Exam	75.00
Comparative / Subsequent Review	100.00 per quarter hour

Student (14 years of age to include 18 years of age)*

Initial Consultation/Examination	150.00
Radiographic (x-rays) – per view	50.00
Thermographic and EMG Scans – per scan	45.00
Report of Findings (1 hr. - additional billed at hourly rate)	100.00
Chiropractic Adjustment	75.00
Comparative Exam	75.00
Comparative / Subsequent Review	100.00 per quarter hour

Child (13 years and under)*

Initial Consultation/Examination	125.00
Radiographic (x-rays) – per view	50.00
Thermographic and EMG Scans – per scan	45.00
Report of Findings (1 hr. - additional billed at hourly rate)	100.00
Chiropractic Adjustment	70.00
Comparative Exam	75.00
Comparative / Subsequent Review	100.00 per quarter hour

* Child and Student fees apply to children and students who have a minimum of 1 parent under a care plan with Dr. Moore at the time of the initial visit and upon subsequent care plans.

I have reviewed, understand and accept the fee structure as set out above.

Patient Initials _____

Other Services

Consultation/Extended Treatment with Dr. Moore	$100.00 per ¼ hour
Custom Orthotics	$600.00
Dispensary Products	Priced Individually
Acupuncture	$95.00 per session
Spinal Decompression	$250.00 per session
Records / Administrative Forms or Reports	Priced Individually @$400.00 / hr
Communications (email, text, telephone)	$100.00 per ¼ hour
Emergency Fee	$150.00 in addition to services
Out of Hours appointments	$75.00 in addition to service

I have reviewed, understand and accept the fee structure as set out above. Patient Initials _____

ABOUT BILLINGS

All services are billed at the discretion of the doctor at the time of service. Care plans are an estimate of the services that will be used throughout the course of care however, other services not included in the care plan may be used and will be billed at the customary rates enclosed above. Any changes or additions to a care plan are billed at the rates above. By beginning care you agree to fees as set out above and understand that you are responsible for all billings. The office has a no receivable policy and as such payment is due in advance or on the day of for all services.

ABOUT OHIP

Currently OHIP does not cover any portion of services offered at the Canadian Disc Institute.

EXTENDED HEALTH CARE PLANS

Please check with your insurance company regarding your benefits. In order to be reimbursed by your insurance company, the Canadian Disc institute will assist you with a financial record which must be submitted with your claim. However, we do require payment for services rendered on the day of your appointment. We cannot guarantee that your insurance company will make payment for the same.

NO FAULT MOTOR VEHICLE INSURANCE

If you are attending the Institute due to a claim filed with your provincial No Fault Motor Vehicle Insurance, payment must be made directly to the Canadian Disc Institute by yourself at the time the program is initiated. The Canadian Disc Institute will assist you with the required documentation to facilitate your claim, but cannot guarantee any portion of the claim will be honoured by your insurance company.

WORKERS' COMPENSATION BOARD

Should you be eligible for coverage under the Workers' Compensation Board of Ontario, it is imperative you advise the Canadian Disc Institute of this situation on your first visit.

Currently, the WSIB does not cover decompression therapy such as that offered at the Canadian Disc Institute. This means that even if you are eligible for WSIB coverage they will not assist with financial coverage of services offered at the Canadian Disc Institute.

If you have any questions with respect to matters set out above or if we have failed to cover any area of concern to you, please do not hesitate to ask our staff. We value you as a patient and want to do everything we can to help you to return to an active, pain free life.

Sincerely,

The Canadian Disc Institute

PATIENTS ACCEPTANCE OF POLICIES

I, _____ understand that the information provided herein is strictly confidential and is utilized to assist in more fully understanding my case. I understand and accept all policies and fees of the Canadian Disc Institute as set out above.

_____ _____

Patient's Signature Date

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

Section 1 - Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self -care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

Section 7 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

Section 9 – Reading

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

Section 10 – Recreation

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

moore chiropractic group

Informed Consent to Chiropractic

Consent to Examination

Your chiropractic care at this office will be based upon the details of your personal health history, as well as detailed orthopedic and neurological testing. Radiographic studies may be recommended. During the course of this testing the doctor will be asking you to bend, twist and move. Additionally, the doctor will palpate areas of your spine and muscles.
I have read the above and consent to undergoing an examination as mentioned but not limited to the above.

Print Name _____ Signature _____ Date _____

Consent to Chiropractic Care

Chiropractors locate, analyze and correct vertebral subluxations, which are misalignments of spinal joints, which cause nervous system imbalances. Chiropractic care, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective for spinal pain, headaches and other similar symptoms. Chiropractic care can greatly contribute to your overall well-being and good health. Chiropractors may utilize chiropractic adjustments, soft tissue therapy and occasional modalities such as ultrasound and interferencial current during your care.

Chiropractic care is considered to be one of the safest forms of health care; the risk of injuries or complications is substantially lower than that associated with medical or other treatment, medications and procedures given for the same symptoms. However, all treatment or manual therapies contain some risks, however rare, that you should be aware of including ligament sprains, muscle strains, and rib fractures. There are rare reported cases of disc injuries identified following certain cervical and lumbar spinal adjustments, although no scientific evidence has demonstrated such injuries are caused by or may be caused by spinal adjustments or other chiropractic care.

There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because of the serious neurological impairment a stroke may cause. The possibility of such injuries occurring in association with upper cervical chiropractic is extremely remote.

I acknowledge I have read this consent and I have discussed or had the opportunity to discuss with the doctor this consent, the nature and purpose of chiropractic care in general, treatment options, and recommendations for care.

I consent to the chiropractic care offered at this office and I intend this consent to apply to all my present and future chiropractic care.

Print Name _____ Signature _____ Date _____

DC Initials _____

Spinal Decompression

Informed Consent to
Vertebral Axial Decompression Treatment Program

I hereby request and consent to the performance of vertebral Axial Decompression treatments on myself by doctors and or clinical personnel of Moore Chiropractic Group.

I have had an opportunity to discuss with the doctor and or clinical personnel the nature and purpose of spinal decompression and I understand there is no guaranteed clinical response.

I wish to rely on the doctor and/or clinical personnel to exercise judgment during the course of the procedure of Vertebral Axial Decompression which based upon the facts known at the time are in my best interest.

I have read the above consent. I have had an opportunity to ask questions about this consent and by signing below I agree to Vertebral Axial Decompression therapy.

_____
Patient Signature

_____
Patients Name

_____
Date

_____
Witness to Signature

A non-surgical solution to back pain

265 Edward St. Suite 7 Aurora, Ontario L4G 3M7 Tel: 1-866-760-VAXD Fax: 905-841-3439
e-mail: dr.moore@vax-dcanada.com www.vax-dcanada.com

Instructions to Patients Undergoing Decompression

Treatment time on the table is approximately 34-38 minutes per session. **Please arrive 10 minutes prior to each appointment.** Each treatment consists of 15 cycles of decompression, alternating with relaxation. Each distraction and relaxation phase is controlled through a variable timer. The protocol calls for 60 seconds of distraction and 60 seconds of relaxation. This does not include the time it takes for the movable section to slowly react between cycles. The table returns until it reaches the baseline pretension level which is approximately 20-24 pounds of tension.

A. Clothing worn during treatment should be loose and comfortable, and must separate at the waist.

B. All physical therapy, work hardening, exercise programs and sports should be discontinued once treatment commences.

C. You are advised to refrain from lifting, sitting for prolonged periods of time, and do no excessive bending, twisting or pulling in the initial phase. During the period that the patient is on a daily course of VAX-D, all exercises that result in flexion or rotation of the lumbar spine should be avoided as well as activities that require running or jogging. Any exercise that increases intradiscal pressure is contraindicated during the treatment period. Walking is permitted and should be encouraged as long as it does not cause discomfort or muscle spasm.

Patients requiring disc decompression require one session each day. A normal treatment session is about 36 minutes duration plus the time it takes for patient set-up and discharge (approximately 45 minutes in total).Patients are instructed not to begin treatment unless they are able to commit to the daily treatment schedule.

As the 20 daily treatments are completed the patient is then advised to commence treatment once per week for five weeks.

A follow up MRI is suggested at this time.

Every five visits EMG and Thermographic scan will be preformed to monitor progress of nerve compression release.

Patient Initials_____

Canadian Disc Institute

VAX-D Patient Instructions

The VAX-D decompressive program is designed to restart the hydrostatic pump in the discs of the lumbar or cervical spine and to begin the structural correction so as to reduce stress on the discs that result from abnormal spinal alignment. As such, this program is not about what you feel but is about how the structure is functioning. Please remember it is the abnormal alignment that caused the disc to herniate initially. The instructions below are designed to assist you in achieving the best results possible.

Clothing

Clothing must separate at the waist. Pants need to be well fitting without the need for a belt and shirts need to be long enough that they could tuck into pants and have long or short sleeves – no tank tops. The fabric must not be stretchy or sheer so as to avoid slippage due to friction. Any leather belts must be removable.

Personal Hygiene

Out of respect for others please ensure you are clean and free from dirt, dust and debris. Please avoid using perfumes and colognes prior to your decompression session.

While you are on VAX-D

The equipment is extremely sensitive. Tugging, pulling, sneezing, coughing and general movement will affect the effectiveness of your session and may damage the equipment. While you are on the table you must keep your arms down and you elbows at your side. Our staff will always assist you on and off the table. Never attempt to do this on your own.

Daily Activities

Any activity that results in you bending forward at the waist, bending and twisting or twisting should be avoided for the duration of the program and until Dr. Moore advises. These activities include house work such as vacuuming, mopping, washing dishes, doing laundry, gardening, lifting children etc. Any prolonged sitting, standing, lying or walking are to be avoided. For the duration of the program any sports are to be avoided. It is essential any activity that engages core musculature is avoided as muscular contraction of this type will directly increase intradiscal pressure. Dr. Moore will advise as to your return to activities as you progress through the corrective program.

Generally, patients with low to moderately active employment situations may remain working throughout the program with some possible modifications. Patients with highly active or repetitive employment activities may need to be placed on temporary leave or modified duties in order for the program to be completed with the best results possible.

Gentle and short duration activities are allowable and encouraged. These activities may include easy short duration walking, light swimming (no laps), and upright biking. If you would like to participate in other light activities please discuss them with Dr. Moore prior to taking part.

Lifestyle

During this time your body will be doing a lot of healing and your lifestyle will affect how well your body heals. The following are best recommendations: Get 6-8 hours of uninterrupted sleep in a bed that is supportive; If you are over weight please be aware to reduce your intake as extra weight places additional stress on the spine; Habits such as alcohol and smoking and drugs

Dr. Brian R. Moore
15000 Yonge Street
Aurora, Ontario
L4G 1M6

Experience Counts, Results Define

Toll Free: 1-866-760-8293
Local: 905-727-1817
Fax: 905-841-3439
www.canadiandiscinstitute.com

(prescription or otherwise) should be avoided as much as possible as they are toxic to your body and do not promote a healing environment. Please ensure that Dr. Moore is aware of any habits and the extent to which you partake as this can greatly affect your results; Remember all healing takes time. Physical, chemical and emotional stressors have all contributed to the current disc health you experience thus having a positive attitude is vitally important to your results!

Feeling Better

At some point throughout the program you will start to feel better and will want to increase your activity level – Don't! You are in the very early stages of healing and must be very careful not to set yourself back. Very much like when a cast is applied, it is not removed until more complete healing and stability is achieved. Even then, the bone is still weak as the matrix is not fully developed. At the completion of the decompression program your body is still doing a lot of healing and structural correction is not complete and therefore it is very easy to set yourself back. Remember, the disc will hydrate for up to a year after decompression and you need to allow it that chance without creating load on it. That does not mean you can't do anything for that period of time, it just means you need to be careful. Dr. Moore will assist you in returning to activities as you are ready and able.

Not following care recommendations can result in sacrificing your results to date. We are very serious about your results and if Dr. Moore deems that you are not following recommendations he will advise you of this but may also stop your care program if he feels you will not achieve the desired result based on these actions.

This program is not about how you feel. Some of you will experience amazing pain reductions early in the program. It is important to understand this program is about creating enough negative pressure to allow retraction of the disc off the involved nerve root and to restart the hydrostatic pump which allows healing of the disc to take place. The structural corrective care program following decompression is vital to your continued success. Correction of structural alignment will ensure continued hydration of the disc and ultimate neurological function.

I understand the above instructions are designed to allow me to achieve the very best results possible from my decompression program and that any deviation from this may jeopardize the results I achieve.

Patient Name (Printed)	Patient Signature
Doctor Signature	Date