Kinetic Health

At Kinetic Health we employ a variety of techniques to resolve a broad range of soft-tissue and joint-related injuries, including:

- Achilles Tendonitis
- Ankle Injuries
- Back Pain
- Bunions
- Carpal Tunnel Syndrome
- Foot Pain
- Foot Injuries
- Frozen Shoulders
- Gait Imbalances
- Golfer's Elbow
- Golf Injuries
- Hand Injuries
- Headaches
- Hip Pain
- Illiotibial Band Syndrome
- Knee Pain
- Leg Pains
- Muscle Pulls and Strains
- Neck Pain
- Plantar Fasciitis
- Repetitive Strain Injuries
- Rotator Cuff Syndrome
- Running Injuries
- Scar Tissue Formation
- Sciatica
- Shin Splints
- Shoulder Pain
- Sports Injuries
- Swimmers Shoulder
- Tennis Elbow
- TMJ
- Weight Lifting Injuries
- Whiplash
- Wrist Injuries

Kinetic Health

Soft-Tissue and Sports Improvement Systems
Bay #10 – 34 Edgedale Drive NW
Calgary, Alberta
T3A-2R4

Phone:
403-241-3772

Fax:
403-241-3846

Email:
kinetichealth@shaw.ca

Websites:
www.kinetichealth.ca
www.activerelease.ca
www.releaseyourbody.com

Motor Vehicle Accident Report – Information and History

This report, and the Standard Patient Admittance Form, must both be completed **before** *arrival at the clinic. This level of detailed information is required in order for us to complete our diagnosis, and especially if the case involves future litigation.*

Date: _____

Name: _____
(Family Name) *(First Name)* *(Initials)*

Contact Information

Home Address: _____

Postal Code: _____

Phone (h): _____ Phone (w): _____

Phone (c): _____ Email: _____

Note: All Email addresses are strictly confidential and are never given out to other sources. We maintain a no-spam policy. We use emails to confirm appointments, provide you with exercises, health updates, and clinic newsletters. Email also provides you with a means of asking your practitioner questions when they are not able to answer phone calls (while treating patients). At any time you can chose to opt-out of our email information.

Details

Sex: ☐ Male ☐ Female Occupation: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Name of Spouse:

_____

Health Information

Alberta Health Care #: _____

Family Doctor: _____

Phone: _____

Emergency Contacts

Who should we contact if there is an emergency?

Name: _____ Phone: _____

Would you like to see a particular Physician?

☐ YES ☐ It does not matter If YES: ☐ **Dr. Abelson** ☐ **Dr. Mylonas**

How did you hear about Kinetic Health?

In this Report:

Describe the Accident

☐ Did you go to the hospital after the accident? ☐ YES ☐ NO

☐ Were X-rays or other diagnostic procedures used at the hospital? ☐ YES ☐ NO
If YES, what treatment procedures were used, and what were the results?

☐ Did you receive treatment or medication at the hospital? ☐ YES ☐ NO
If YES, what treatment or medication or advice was given at the hospital?

☐ Have you seen any other practitioners about this accident (beside the hospital) before coming to our clinic? ☐ YES ☐ NO
If YES, what examinations, treatment, diagnosis or advice have you been given?

Vehicle Information

Patient Vehicle – check the correct options

What was the **make** of your car/truck?

What was the **size** of your car/truck?

How **far** did your car move after being struck?
_____ in/ft.

What was the approximate **speed** of your car at the time of the collision?
☐ Standing still
☐ 5 to 10 mph
☐ 10 to 15 mph
☐ Other _____

If your vehicle was **standing still** at the time of the collision, did you have your foot or feet:
☐ Pressed on the brake?
☐ Resting on the brake?
☐ Off the brake?

What **direction** did the striking vehicle come from?
☐ Head-on
☐ From behind
☐ Right side
☐ Left side

Did your vehicle **strike another vehicle** after the initial impact? ☐ YES ☐ NO

Did **air bags** deploy? ☐ YES ☐ NO

What kind of **surface** were you driving on?
☐ Dry pavement
☐ Wet pavement
☐ Gravel
☐ Snow
☐ Other _____

What direction was your car's **front tire** facing when your vehicle was struck?
☐ Straight ahead
☐ Right
☐ Left

☐ Were you the **driver**? ☐ YES ☐ NO

If **NO**, where were you sitting?
☐ Front left ☐ Back left
☐ Front middle ☐ Back middle
☐ Front right ☐ Back right

Were you **wearing seat belts**? ☐ YES ☐ NO
If *YES*, what kind?
☐ Shoulder only
☐ Lap only
☐ Combination of shoulder and lap

Was there any **damage** to your vehicle? ☐ YES ☐ NO

If *YES,* provide details.

Striking Vehicle – check the correct options

What was the **make** of the striking car/truck?

What was the **size** of the striking car/truck?

What was the approximate **speed** of the striking vehicle at the time of the collision?

☐ Standing still ☐ 5 to 10 mph _____
☐ 10 to 15 ☐ Other _____

Was there any **damage** to the striking vehicle? ☐ YES ☐ NO

If *YES*, what type and degree of damage?

Vehicular and Patient Relationship

Seat and Head Rest – check the correct options

Did your seat have a **headrest**? ☐ YES ☐ NO

If your seat had a headrest, how far away was the headrest in relationship to the **back of your head**?

☐ 0 to 1 inch
☐ 1 to 2 inches
☐ 2 to 3 inches
☐ Estimated distance _____

If your seat had a headrest, where was the top of the headrest in **relationship** to the **top of your head**?

☐ The top of the headrest came **below** the top of my head by _____ inches.
☐ The top of the headrest was **even** with my head.
☐ The top of the headrest was **above** my head by _____inches.

Facts about the Patient *during* this MVA Accident

Check the appropriate options

Did you **realize** that your car was going to be hit by the other car?

☐ YES ☐ NO

If *YES*, did you brace your arms and legs?

☐ YES ☐ NO

When your car was struck, **what direction** were you looking?

☐ Straight ahead ☐ To the left
☐ Looking down ☐ To the right
☐ Looking up

Did your **head strike** any objects during the impact (for example: window, steering wheel, etc.)?

☐ YES ☐ NO

If *YES*, provide details:

Check the appropriate options

Did you lose consciousness after impact?

☐ YES ☐ NO

If *YES*, for how long?

Did you experience any of the following after the accident?

- ☐ Blurred Vision
- ☐ Confusion
- ☐ Extreme drowsiness
- ☐ Loss of Short Term Memory
- ☐ Nausea or Vomiting
- ☐ Severe headache
- ☐ Trouble understanding conversations
- ☐ OTHER – Provide details

Facts about the Patient *after* the MVA Accident

Check the appropriate options

What do you remember **immediately after** the accident?

Since the accident have you noticed any of the following symptoms**?**

Headaches	☐ YES	☐ NO
Light-headedness	☐ YES	☐ NO
Dizziness or spinning sensation	☐ YES	☐ NO
Poor concentration	☐ YES	☐ NO
Nausea or vomiting	☐ YES	☐ NO
Irritability, feeling frustrated	☐ YES	☐ NO
Easily tired	☐ YES	☐ NO
Problems sleeping	☐ YES	☐ NO
Intolerance of loud noises	☐ YES	☐ NO
Ringing in the ears	☐ YES	☐ NO
Intolerance bright lights	☐ YES	☐ NO
Feeling anxious	☐ YES	☐ NO
Feeling depressed	☐ YES	☐ NO
Crying for no apparent reason	☐ YES	☐ NO
Memory problems	☐ YES	☐ NO
Lack of awareness of surroundings	☐ YES	☐ NO

Previous History of MVA Accidents

Check the appropriate options

Have you ever been in a previous motor vehicle accident?

☐ **YES** ☐ **NO**

Patient Signature: _____

☐ If *YES,* please provide all information about prior accidents.

☐ If *NO*, proceed to the next section.

Date and location of previous MVA #1:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident (if known)

3. Were all symptoms from this prior accident resolved before your most recent accident?
   ☐ **YES** ☐ **NO**
   ☐ If *NO*, what symptoms of this prior accident persisted?

   ☐ If *NO*, then did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident?
   ☐ **YES** ☐ **NO**

Date and location of previous MVA #2:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident (if known)

3. Were all symptoms from this prior accident resolved before your most recent accident?
   ☐ **YES** ☐ **NO**
   ☐ If *NO*, what symptoms of this prior accident persisted?

   ☐ If *NO*, then did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident?
   ☐ **YES** ☐ **NO**

Date and location of previous MVA #3:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident (if known)

3. Were all symptoms from this prior accident resolved before your most recent accident?
   ☐ **YES** ☐ **NO**
   ☐ If *NO*, what symptoms of this prior accident persisted?

   ☐ If *NO*, then did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident?
   ☐ **YES** ☐ **NO**
   ☐

Chief Complaints after this Motor Vehicle Accident (MVA)

Provide required details
Describe all the symptoms and conditions from which you suffered **after the current MVA accident**.
Describe the **physical problems** that you have. Use additional pages if necessary.

What are your primary injuries resulting from this motor vehicle accident?
Please list each area or area of symptoms of the body separately.

Chief Complaint #1:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Chief Complaint #2:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Kinetic Health

Chief Complaint #3:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Chief Complaint #4:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Chief Complaint #5:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Chief Complaint #6:

Area of injury:

Onset:

Is this area of injury a direct result of this MVA:
☐ **YES** ☐ **NO**

Provocative Factors:

What makes this area of complaint worse?

What makes this area of complaint better?

Quality of Pain:

What words would you use to describe the pain?

Radiation of Pain:

Where is the pain located, and does it radiate to anywhere else from this point?

Severity of Pain:

On a scale from 1 to 10, 1 being minimal pain and 10 being worst pain you can imagine, where on this scale is your current level of pain

1 2 3 4 5 6 7 8 9 10

Time:

☐ The pain is constant.
☐ The pain worse in the morning.
☐ The pain worse in the evening.
☐ The level of pain varies with body position (sitting, standing, lying down).
☐ The level of pain is worse with motion.
☐ The level of pain is better with motion.

Informed Consent for Chiropractic Adjustments and Soft Tissue Therapy

Kinetic Health®

Dr. Brian Abelson D.C. and Dr. Evangelos Mylonas D.C.
Soft Tissue Management Systems
Bay #10 – 34 Edgedale Dr. N.W.
Calgary, Alberta, T3A-2R4
403-241-3772

I hereby request and consent to the performance of Chiropractic Adjustments and other Chiropractic procedures, including but not limited to various modes of manual/physical therapy (Active Release Techniques, Graston Techniques, TCM procedures, Acupuncture, Therapeutic Stretching, Massage, and, if necessary, diagnostic x-rays), upon myself by **Dr. Brian Abelson DC** or **Dr. Evangelos Mylonas DC**, and/or other office or clinic personnel.

I further understand, and am informed that, as in all health care, in the practice of Chiropractic, there are some **very slight risks** to treatment, that include, but are not limited to the following:

1. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

2. 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. Recent studies suggest 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 a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

3. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

4. There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. Chiropractic 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 back pain, and musculoskeletal pain. As with any healing/medical profession I understand there are no guarantees of cure or guarantees of full resolution of my condition.

I acknowledge that I have discussed, or have had the opportunity to discuss, with either Dr. Abelson, his associates, or staff, the nature and purpose of Chiropractic treatment in general and my treatment in particular, as well as the contents of this Consent Form. I therefore intend this consent to apply to all my present and future Chiropractic care/Spinal adjustments and other treatments with Dr. Abelson, and his associates, at this or other clinic locations, sporting, or other media events.

Patient Authorization for Treatment

Patient's Name: _____ **Witness Name**: _____

Patient Signature: _____ **Witness Signature**: _____
Patient must be of legal age (18 years) to sign this Consent

Date: _____ **Date**: _____

Parent or Legal Guardian

Legal Guardian Name: _____ **Legal Guardian Signature**: _____

Date: _____

Clinic Information

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 AM to 6:30 PM	8:00 AM to 5:00 PM	8:00 AM to 7:00 PM	8:00 AM to 7:00 PM	8:00 AM to 5:00 PM	10:00 AM to 2:00 PM	Closed

Note: Clinic will be closed on all statutory holidays.

Fee Schedule

- For information about specific fees, please phone our clinic at **403-241-3772.**
- Payment is due upon services being rendered. We kindly accept cash, debit card, MasterCard, Visa and American Express.

Extended Insurance

- Please note: It is the patient's responsibility to confirm extended coverage with their insurance company. We DO NOT directly bill secondary insurance companies on your behalf, but we will be gladly assist you with your individual insurance forms.

Motor Vehicle Accident Cases

- Kinetic Health accepts MVA cases. If your claim is to be processed through MVA insurance, please notify the staff at Kinetic Health in advance, or upon your first visit. Kinetic Health will not be held responsible for payments that are not reimbursed by MVA insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Worker's Compensations Board

- Kinetic Health accepts WCB cases. If your claim is to be processed through WCB insurance, please notify the staff at Kinetic Health in advance, or upon your first visit. Kinetic Health will not be held responsible for payments not reimbursed by WCB insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Contact Information

Phone: 403-241-3772
Fax: 403-241-3846
Email: kineticheath@shaw.ca
Web Sites: www.kineticheath.ca
www.releaseyourbody.com