INJECTION THERAPY

Hamilton Back Clinic is continuing to be innovative and progressive in the treatment of muscle and joint related pain with the addition of Injection Therapy.

Injection Therapy involves the injection of therapeutic solutions (Traumeel and other solutions in combination) into chronic or long standing tissue injury with the purpose of decreasing inflammation and improving tissue healing. The solution is injected beneath the skin to desensitize nerve endings around the injured area. This interrupts the pain signals going from the area of injury to the spinal cord and stimulates tissue repair.

This desensitization gives Dr. Lombardi the opportunity to restore the mechanics of the tissues by using active muscle release without causing a spasm. This is because once the injection desensitizes the area of injury the tissue becomes easier to manipulate manually. The active release not only breaks up scar tissue; but it improves the circulation of the injected solution throughout the tissue. This combination increases tissue flexibility, reduces inflammation and improves tissue repair.

Although injection therapy is performed in Europe; this approach is unique because it is done in conjunction active muscle release. Following the injection with a series of manual treatments accelerates the mechanical and chemical changes which occur during soft tissue healing. Injuries caused by a history of trauma (auto accidents, falls, sports, orthopedic surgery) are ideal candidates since scar tissue begins to form as early as three weeks after trauma.

The injections are performed by Dr. Susan Slipacoff who is a naturopath fully trained in neural therapy. Neural therapy focuses on normalizing the function of nerves and soft tissue.

For more information contact 905.692.4222. This program begins October 3.

Injection Therapy Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Gentle techniques are used in order to stimulate the body's inherent healing capacity.

It is very important that you disclose any condition that you are suffering from and any medications/over the counter drugs that you are currently taking. Please also disclose if you are pregnant, suspect you are pregnant or if you are breast-feeding.

It has been recommended that you receive injection therapy to compliment the therapy you are receiving from the Hamilton Back Clinic. I understand that even naturally oriented procedures such as this carry some amount of risk. For examples, with any needles there is the small risk of causing bleeding, bruising, infection or nerve injury. Supplements, procaine (Novocain) or other oral/IV injected medicines carry a slight risk of allergic or other reactions in certain individuals however such reactions are very rare. I will always retain the right to accept, reject or discontinue any treatment, before or during any procedure.

Though these medical methods have benefited many people, I understand that no practitioner can ever guarantee results, yet I understand that Dr. Slipacoff, ND will do her best to inform me of the possible outcomes of diagnostic and therapeutic procedures. Similarly, I know that the frequency and number of treatments required for my medical problems is not easily or accurately predictable, but it is my expectations that a series of 2-4 injection treatments will be performed and that Dr. Slipacoff, ND will communicate her best estimates. I accept the fact that outcomes of treatment vary from little help to full resolution of symptoms, but more commonly success will be defined as clearly perceivable improvement of my pain and injury.
In the case of circumstances that lead me to miss a future scheduled appointment, I will make every effort to call the Hamilton Back Clinic to provide as much notice as possible.

Name:_____ Date:_____

Signature:_____

Dr. Anthony J. Lombardi
&
Dr. Susan Slipacoff N.D

Injection Therapy Adult Intake Form

PLEASE COMPLETE THIS FORM AND RETURN IT TO RECEPTION

Personal Information

Name_____ Date _____

Date of birth ___/___/_____ Sex: M___ F___
MM /DD/ YYYY
Emergency contact:
Name: _____

Phone #:_____ Relation:_____

Medical History:
How would you describe your general state of health?
Excellent__ Good__ Fair__ Poor__

Please list any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.
_____
_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)
_____
_____
_____

Do you have any allergies? If so, please list them below:
_____
_____