Welcome to PHYSICAL THERAPY SERVICES, P.A.

Name:_____ Date:_____
First M Last

Mailing Address:_____
City State Zip

Home Phone:_____ Cell Phone:_____

Emergency Number:_____ Relationship:_____

Date of Birth:_____ Age:_____ SSN:_____ Height:_____ Weight:_____

Referring Physician:_____ Reason for Referral:_____
Date of Injury/Condition:_____ Date of Surgery:_____

**Is this a work related injury?**_____

**Have you RECENTLY noted any of the following (check all that apply)?**

| | | |
|---|---|---|
| ☐ Fever/Chills/Night Sweats | ☐ Weight Loss/Gain | ☐ Difficulty maintaining balance while walking |
| ☐ Numbness/Tingling | ☐ Muscle Weakness | ☐ Changes in bowel and/or bladder function |
| ☐ Headaches | ☐ Dizziness | ☐ Shortness of Breath |
| ☐ Chest pain at rest | ☐ Night Pain | ☐ Changes in vision |
| ☐ Nausea/Vomiting | ☐ Fatigue | ☐ Fainting |
| ☐ Heartburn/Indigestion | ☐ Constipation | ☐ Changes in menstruation |

Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

**Have you EVER been diagnosed with or have any of the following (check all that apply)?**

| | | | | |
|---|---|---|---|---|
| ☐ Cancer | ☐ Heart Problems | ☐ Implants | ☐ Stroke/CVA | ☐ Blood Clots/DVT/PE |
| ☐ Pacemaker | ☐ Latex Sensitivity | ☐ Chest Pain | ☐ Anemia | ☐ High Blood Pressure |
| ☐ Diabetes | ☐ HIV/AIDS | ☐ Asthma | ☐ Tuberculosis | ☐ Hepatitis |
| ☐ Seizures | ☐ Thyroid Problems | ☐ Neuropathy | ☐ Lung Problems | ☐ Heart Attack |

☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Other Arthritic Condition(s) ☐ COPD
☐ Osteoporosis/Osteopenia ☐ Depression ☐ Other_____

**Please list any previous surgical history:**_____

**List of Medications:**_____

**Allergies: List any medications you are allergic to:**_____

I authorize and consent for treatment and authorize the release of any medical information necessary to process the claim, and authorize and assign payment of medical benefits directly to PHYSICAL THERAPY SERVICES for services rendered. I understand that I am financially responsible for all charges covered by this authorization, including 35% costs of collections and attorney's fee.

_____
Patient/Responsible Party Signature Printed Name Date

# HIPAA FORM 2019

Medical records and patient information confidentiality policy:

In compliance of state and federal regulations, Physical Therapy Services will not release an individual's medical records or information without the patient's written authorization. The patient may restrict or revoke the authorization to release medical information at any time. We ask that you instruct us on what medical information can be shared, with whom, and by what means of communication.

May Physical Therapy Services contact you by phone and, if no answer, leave a message for appointments, scheduling, referrals or other information?

_____ Yes _____ No

Preferred method of communication for service reminders such as scheduling/referrals, statement reminders and appointment reminders:

_____ Phone _____ Letter _____ Email _____ Text

Currently all methods may or may not be available for use.

If Physical Therapy Services cannot reach you, is there another person whom we can discuss your medical information? Please list relationship/contact phone numbers:

Name: _____ Relationship:_____ Phone#:_____

Name: _____ Relationship:_____ Phone#:_____

Name: _____ Relationship:_____ Phone#:_____

If patient is a minor, I authorize the following people to bring my child to Physical Therapy Services for treatment:

Name: _____ Relationship:_____ Phone#:_____

Name: _____ Relationship:_____ Phone#:_____

_____ _____

Patient/Responsible Party Signature Date

E-Mail: _____

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DOCTOR OF HEALTH SCIENCES,
PHYSICAL THERAPIST
CLINICAL SPECIALIST
ORTHOPEDIC AND SPORTS
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THERAPY
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SUITE 1
ELIZABETHTON, TN 37643-3787
423•543•0073
423•543•1277 FAX
423•335•4530 MOBILE
ptsstaff@yahoo.com

1500 WEST ELK AVENUE
SUITE 104
ELIZABETHTON, TN 37643
423•543-2215
423•543-2218 FAX
ptsstaff3@yahoo.com

# PATIENT APPOINTMENT POLICY

Any appointments that you are unable to attend, please contact out office immediately to cancel.

After three consecutive no-call and/or no-show appointments it will be grounds for dismissal and all future appointments will be cancelled. It is important to notify our office if you are unable to keep your scheduled appointment.

Patient's that do not return for treatment after 30 days or more will be discharged and referring physician will be notified. A new order may be required for treatment and all balances must be paid prior to resuming therapy.

Thank you for your cooperation,

Office Staff

_____ _____

Responsible Party (Print) Date

_____

Responsible Party (Signature)

"EXCELLENCE IS THE RESULT OF
CARING MORE THAN OTHERS THINK IS WISE
RISKING MORE THAN OTHERS THINK IS SAFE
DREAMING MORE THAN OTHERS THINK IS PRACTICAL AND
EXPECTING MORE THAN OTHERS THINK IS POSSIBLE"

# DRY NEEDLING CONSENT & INFORMATION FORM FOR PHYSICAL THERAPY SERVICES

**What is Dry Needling?**

Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupunctures or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("*Qi*") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

**Is Dry Needling safe?**

Drowsiness, tiredness or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

**Is there anything your practitioner needs to know?**

1. Have you ever fainted or experienced a seizure? YES/NO
2. Do you have a pacemaker or any other electrical implant? YES/NO
3. Are you currently taking anticoagulants (blood-thinners e.g. aspirin, warfarin, coumadin)? YES/NO
4. Are you currently taking antibiotics for an infection? YES/NO
5. Do you have a damaged heart valve, mental prosthesis or other risk of infection? YES/NO
6. Are you pregnant or actively trying for a pregnancy? YES/NO
7. Do you suffer from metal allergies? YES/NO
8. Are you a diabetic or do you suffer from impaired wound healing? YES/NO
9. Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? YES/NO
10. Have you eaten in the last two hours? YES/NO

**Single-use, disposable needles are used in this clinic.**

- **STATEMENT OF CONSENT**

  I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

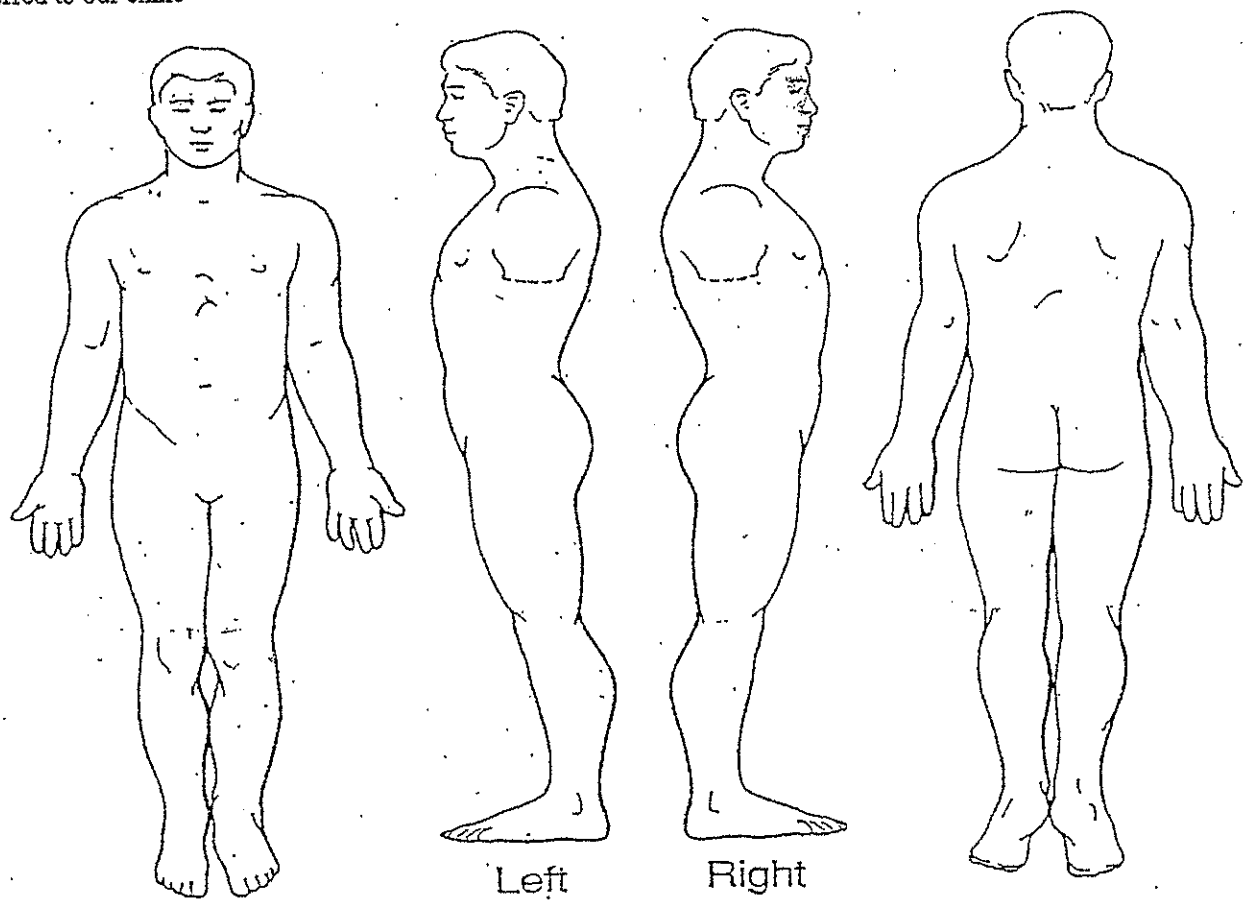
Signature:_____ Date:_____

# Pain Location Diagram and Quality Assessment (PLDQA)

| Last Name | |
|---|---|
| First Name | |
| Referring MD | |
| SS # | DOB |

Date: _____

On the diagrams below, please **shade** the area or areas where you are experiencing the pain that brings you to our clinic, or the pain for which you were referred to our clinic




Listed below are possible ways of describing your typical pain. Please check all of the descriptions that apply to your primary pain:

| | | | | |
|---|---|---|---|---|
| ☐ Throbbing | ☐ Shooting | ☐ Stabbing | ☐ Sharp | ☐ Cramping |
| ☐ Gnawing | ☐ Hot-Burning | ☐ Aching | ☐ Heavy | ☐ Tender |
| ☐ Slitting | ☐ Tiring-Exhausting | ☐ Sickening | ☐ Fearful | ☐ Punishing-Cruel |

How often do you experience your pain? ☐ Constant ☐ Comes and goes ☐ Good days and bad days

Please circle how severe your overall pain is right now, today:

No Pain Mild Discomforting Distressing Horrible Excruciating

Place an X on the line below to indicated how severe your pain is:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

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Patients please do not write here.

Verification: _____ Date: _____