Welcome to Physical Therapy Services, P.A.

Name: _____ Date: _____

First Middle Last

Mailing Address: _____

City State Zip

Home phone: _____ Cell Phone: _____

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

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Referring Physician: _____ Reason for Referral: _____

Date of Injury/ Condition: _____ Date of Surgery: _____

Is this a work-related injury? _____ Is this a school related injury? _____ School: _____

Home Health Dates Received: _____

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

- o Fever/Chills/Night sweats
- o Numbness/Tingling
- o Headaches
- o Chest pains at rest
- o Nausea/Vomiting
- o Heartburn
- o Indigestion
- o Weight loss/gain
- o Muscle weakness
- o Dizziness/ Fainting
- o Fatigue
- o Shortness of breath
- o Currently pregnant or think you might be pregnant
- o Changes in Menstruation
- o Constipation
- o Difficulty maintaining balance while walking

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

- o Cancer
- o Pacemaker
- o Diabetes
- o Seizures
- o Rheumatoid Arthritis
- o Heart Problems
- o Latex Sensitivity
- o HIV/AIDS
- o Thyroid Problems
- o Implants
- o Chest Pains
- o Asthma
- o Neuropathy
- o Stroke/CVA
- o Anemia
- o Tuberculosis/Lung problems
- o Blood clots/DVT/PE
- o High blood pressure
- o Hepatitis
- o Heart Attack
- o Osteoarthritis
- o COPD
- o Depression

Other: _____

Please list any previous surgical history: _____

List of Medications: _____

Allergies: _____

I authorize and consent for treatment and authorize the release of any medical information necessary to process the medical claim and authorize and assign payment of medical benefits directly to Physical Therapy Services for all services rendered. I understand I am financially responsible for all charges covered by this authorization, including but not limited to 35% costs of collections and attorney's fees. I understand that PTS is a learning facility, and I may be working with a Physical Therapy student under the direct supervision of a licensed physical therapist.

Signature: _____ Date: _____

2021 HIPAA & APPOINTMENT POLICY

Medical records and patient information confidentiality policy: In compliance of state and federal regulations, Physical Therapy Services will not release and individuals' medical records or information without patients 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.

Any appointments that you are unable to attend, please contact our 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 canceled.

* Patients 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 balance must be paid prior to resuming therapy.

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

_____YES ____NO

What is your preferred method of communication for appointment reminders, scheduling/referrals, and statement reminders? (Currently all methods may or may not be available for use.)

____PHONE ____LETTER ____EMAIL ____TEXT

If Physical Therapy Services is unable to reach you, is there another person whom we can discuss your medical information? Please list name, relationship and phone number:

Name: _____ Relationship:_____ Phone Number:_____

Name: _____ Relationship:_____ Phone Number:_____

Name: _____ Relationship:_____ Phone Number:_____

If patient is a minor, I authorize the following people to bring / pick up my child to/from Physical Therapy Services:

Name: _____ Relationship:_____ Phone Number:_____

Name: _____ Relationship:_____ Phone Number:_____

Name: _____ Relationship:_____ Phone Number:_____

_____ _____

Signature **Date**

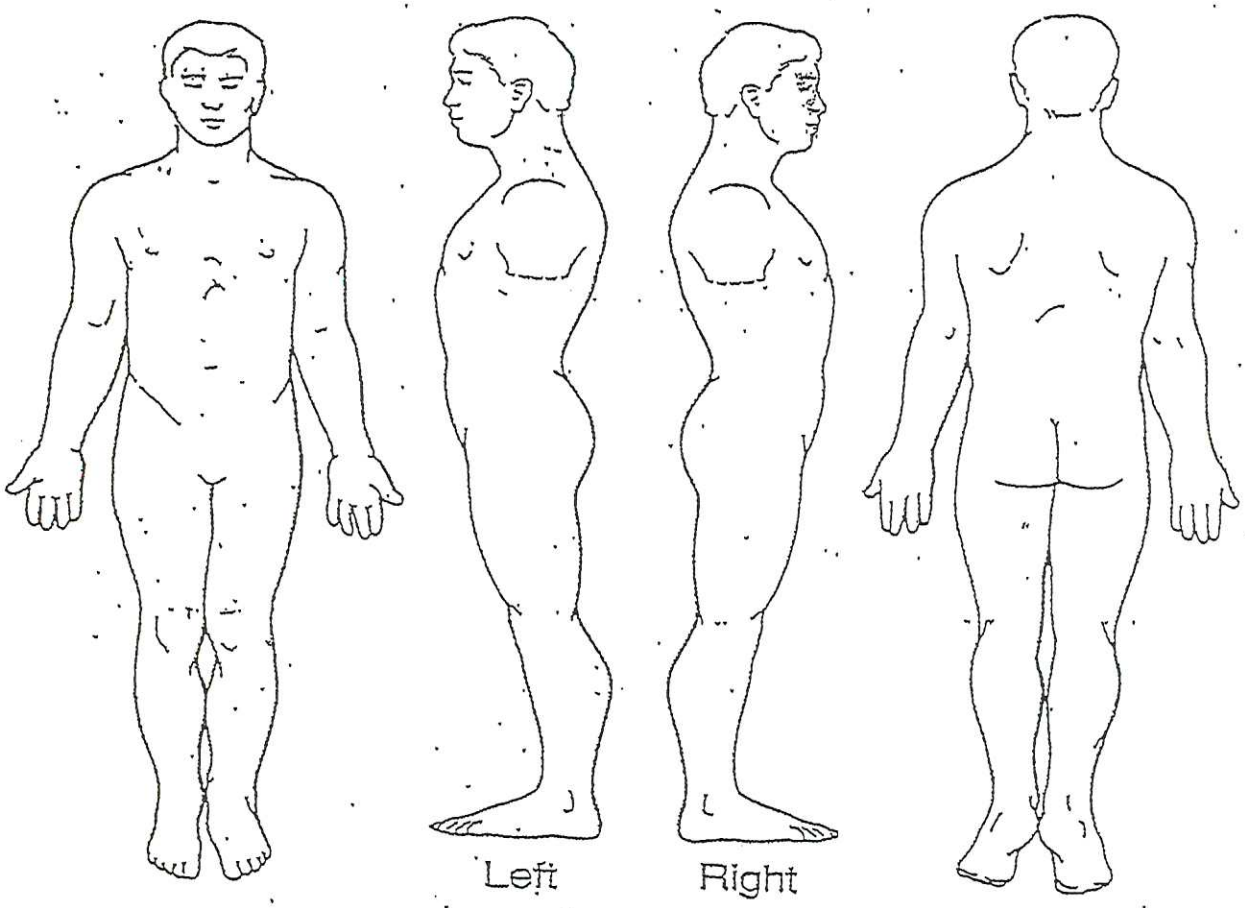
E-Mail: _____

Pain Location Diagram and Quality Assessment (PLDQA)

Date: _____

Last Name	
First Name	
Referring MD	
SS #	DOB

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

Patients please do not write here.

Verification: _____ Date: _____

CONSENT FOR DRY NEEDLING / INFORMATION FORM for PHYSICAL THERAPY SERVICES P.A

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 to simulate a healing response in painful musculoskeletal conditions. Dry needing is NOT acupuncture or oriental medicine; that is, it does 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, and 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. Existing symptoms 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 or patients. The most common serious side effect in pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs of pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, 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 have been reported in the medical literature following needling; however, there are extremely rare events (1 in 200,000).

Things that 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 any anticoagulants (blood thinners e.g. aspirin, warfarin, coumadin)? YES / NO
4. Are you currently taking antibiotics for infection? YES / NO
5. Do you have a damaged heart valve, metal prothesis or other risk for 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 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 had anything to eat in the last 2 hours? YES / NO

Single use, disposable needles are used in this clinic.

- ☐ I confirm that I have read and understand the above information, and I **DO** consent to having dry needling treatments. I understand that I can refuse treatment at any time.
- ☐ I do NOT consent to dry needing treatments.

Patient Signature: _____ **Date:** _____

Parent / Guardian Signature: _____ **Date:** _____