Physical Therapy Medical Screening Questionnaire

Date: _____ **DOB:**_____

Name: _____

Smoker: Y N **Possibly Pregnant:** Y N

Occupation:

Briefly describe your exercise routine:

Past Surgical History:

Current Medications:

Past Medical History: Please circle each condition that you currently have OR have had in the past.

Cancer Diabetes I or II Stroke Blood Clot Pacemaker
Depression Seizures Asthma High Blood Pressure
Heart Disease Liver Disease Kidney Disease Lung Disease
Fibromyalgia Osteoporosis Osteoarthritis Rheumatoid Arthritis
Ulcers Allergies:_____

Other:_____

Recent Illness ?(Please Explain):_____

Recently I have been experiencing (please circle all that apply):

Fever/Chills/Sweats Unexplained Weightloss Increased Pain at Night
Difficulty Speaking Dizziness Poor Balance/Falls Vision Changes
Numbness/Tingling Nausea/Vomiting Chest Pain Shortness of Breath
Changes in Appetite Pain with Meals Unusual pain with Menstruation
Change in (Bowel) or (Bladder) control

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New Patient Registration:

Name: _____ Date: _____

Address:_____

City: _____ State:_____ Zip Code:_____

Phone (Home): _____ Cell: _____

May we leave messages at numbers above? Y / N

Date of Birth: _____/_____/_____ Email: _____

Referring Physician (If Applicable): _____

Name of person we should contact in case of emergency:_____

Phone Number:_____ Relationship to you:_____

How did you find out about our practice?_____

_____

_____

DRY NEEDLING CONSENT & INFORMATION FORM

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 acupuncture 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 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, metal 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 have dry needling treatments. I understand that I can refuse treatment at any time.

Signature: _____

Printed Name: _____

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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Landreneau Physiotherapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name: _____

Signature: _____ Date: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how you your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restrictions, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

_____

This consent was signed by:_____ (Print name please)

Signature:_____ Date:_____