New Patient Intake Form

DEMOGRAPHICS			
Patient Name:		DOB:	
Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:	Work Phone:	
Email Address:	How did you hear about us?		
Emergency Contact Name:	Phone #:	Relation:	

MEDICATION HISTORY - Please include ALL known presciptions and over-the counter medications (including herbal, vitamin, mineral, or dietary supplements) in the boxes below *(or check one of the following boxes)*	
☐ Medication List Attached	☐ Not Currently Taking Any Medications or Supplements
Medication:	**Medication:**
Medication	**Medication:**
Medication	**Medication:**

INJURY / ILLNESS INFORMATION			
Nature of Injury or Illness:	Cause Due To:	☐ Injury/Accident	☐ Surgery
Date of Injury/Surgery/Accident or Date Condition Began:			
Work Status: ☐ Full-Time	☐ Part-Time	☐ Off-Duty	☐ Unemployed
Below please rate your pain on a scale of 0 to 10, where 0 equals no pain and 10 equals the worst pain you can imagine.			
Pain Rating at Worst:	Pain Rating at Best:	Pain Rating Today:	

SURGICAL HISTORY - Please list your surgical history in the boxes below

Type of Surgery	Sugery Date	Type Of Surgery	Surgery Date

PREVIOUS TREATMENT - Have you had any of the following medical, diagnostic, or rehabilitative services for this episode/injury? *(Check all that apply below)*

- ☐ Practitioner
- ☐ Orthopedist
- ☐ Podiatrist
- ☐ Neurologist
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Massage Therapy
- ☐ Chiropractor
- ☐ ER
- ☐ X-Rays
- ☐ MRI Scan
- ☐ CT Scan
- ☐ Myelogram
- ☐ EMG/NCV

PAST MEDICAL HISTORY - Please check any condition you currently have and/or have had in the past. *(Check all that apply below)*

- ☐ Cancer
- ☐ Diabetes
- ☐ Seizures
- ☐ Stroke
- ☐ Concussion
- ☐ Fibromyalgia
- ☐ Pacemaker/Defibrilator
- ☐ Heart Problem
- ☐ Osteoporosis
- ☐ Migraines/Headaches
- ☐ Pins or Metal Implants
- ☐ Neurologic Disorder
- ☐ High Blood Pressue
- ☐ Rheumatoid Arthritis
- ☐ Allergies:______________________

Have you expreienced any of these symptoms recently? (Check all that apply below)

- ☐ Chest Pain
- ☐ Memory Problems
- ☐ Difficulty Speaking
- ☐ Shortness of Breath
- ☐ Unexplained Weight Loss/Gain
- ☐ Dizziness
- ☐ Difficulty Swallowing
- ☐ Change in Bowel Habits/Control
- ☐ Change in Bladder Habits/Control
- ☐ Nausea/Vomiting
- ☐ Poor Balance/Falls
- ☐ Change in Appetite
- ☐ Vision Changes
- ☐ Unusual Pain w/ Menstration
- ☐ Increased Pain at Night/Rest
- ☐ Pain with Meals
- ☐ Unusual Weakness
- ☐ Numbness/Tingling
- ☐ Confusion/Brain Fog
- ☐ Fever/Chills/Sweats

ADDITIONAL INFORMATION

Are you a smoker?	☐ Yes	☐ No	**If yes, how many packs per day?: ________
Do you consume alcohol?	☐ Yes	☐ No	**If yes, how many drinks per day?: ________
Possibility of preganancy?	☐ Yes	☐ No	

By my signature below, I certify that the information I have provided above is complete, accurate, and truthful to the best of my knowledge.

_______________________________ *Patient or Legal Guardian Signature*

_______________________________ *Printed Name*

_______________ *Date*

New Patient Acknowledgements

Patient Name: ______________________________ **DOB:** ______________

Consent to Treatment	
(Patient Initial)	I consent to and authorize dFender Physical Therapy, LLC and its' employees to administrator physical therapy treatment. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of physical therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of physical therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the physical therapy.

Notice of Privacy Practices	
(Patient Initial)	I hereby acknowledge that I have been made aware of dFender's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the front desk and that I may request a copy of any amended Notice of Privacy Practices at any time.

Authorization to Release / Obtain Information	
(Patient Initial)	I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize dFender Physical Therapy, LLC to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondences can be made via mailings, electronic email, telephone and/or facsimile.

Insurance Eligibility	
(Patient Initial)	Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits

Financial Responsibility	
(Patient Initial)	Payment is due at the time of treatment. I agree to pay dFender Physical Therapy, LLC all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

Assignment & Release of Benefits	
(Patient Initial)	I hereby appoint dFender Physical Therapy, LLC as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third-party claim's payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize PPT to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to dFender PT and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to dFender PT not later than ten (10) days after my receipt.

Appointments / Cancellations	
(Patient Initial)	We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for functional improvement. We expect you to keep all of your appointments with dFender Physical Therapy, LLC and require 24 hours' notice if you are unable to keep an appointment. Failure to show up for an appointment will result in a $35.00 charge. These charges are not reimbursed by any insurance company. The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

Patient Signature *(or Responsible Party)*: ______________________________ Date: ______________

Printed Name of Patient *(or Responsible Party)*: ______________________________

Dry Needling Consent Form

Patient Name: ____ DOB: _________________

Your Physical Therapist has recommended that dry needling be utilized in your treatment plan. Dry needling is a very effective treatment technique utilized in conjunction with other physical therapy interventions to inactivate myofascial trigger points and the pain and dysfunction they cause. It involves the use of a very fine (usually 0.3 mm/30 gauge), solid filament, sterile needle (also used for acupuncture) which is inserted into the skin and directly into a myofascial trigger point. Repeated strokes or movements of the needle without completely withdrawing it help to inactivate the trigger point, all of which may take approximately 30-60 seconds at each site. There may be more than one trigger point in a muscle requiring needling, and more than one muscle with trigger points. There is no medication used in this technique.

Dry needling is a technique used in physical therapy practice to treat trigger point in muscles. Dry needling should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.

Benefits of dry needling include pain control/reduction, improvement in range of motion and mobility, improvement in muscle strength and function, and improvement in overall functional ability of the involved areas being treated.

Potential risks and steps to minimize these include:

- **Temporarily increased pain, soreness, or aching in area(s) treated for one to three days following treatment -** *This may be minimized by other treatment interventions used in physical therapy such as modalities (ice, heat, ultrasound, etc.), stretching, and rest from excessive use of the area.*
- **Infection -** *Anytime the skin is penetrated, there is a risk of infection. This risk is minimized with the use of sterile needles, which are disposed of after treatment and never used between patients*.
- **Bruising/bleeding -** *A needle may penetrate an artery or vein, which may cause a small amount of immediate bleeding and possible bruising later. Your physical therapist will do their best to avoid penetrating an artery or vein, and utilize pressure to the site should this occur.* ***The use of some medications that interfere with blood clotting may make this more likely to occur, and you are encouraged to inform your physical therapist of any anticoagulant medication you may be taking.***
- **Penetration of a nerve -** *Your physical therapist will do their best to avoid contacting or penetrating any nerves by thoroughly palpating anatomical locations and avoiding common neural pathways. In the event that a nerve is stimulated, temporary paresthesia (a prickling or tingling sensation) may result. This is usually brief and sometimes only present at the moment the nerve is stimulated. If sufficiently irritated, this sensation may last for a few days, but should fully resolve.*
- **Pneumothorax (penetration of the chest cavity) -** *Even a very small hole in the chest cavity can cause air to accumulate in the space around the lung. This buildup of air puts pressure on the lung, so it cannot expand as much as it normally does when taking a breath. Symptoms may include difficulty breathing or shortness of breath, tightness in the chest, fatigue, and increased heart rate.* ***If you experience any of these symptoms at any time after a dry needling session, proceed to an emergency facility and inform them you have been treated with dry needling.*** *Using extra care and safety precautions when needling muscles near the lungs minimizes the chances of this complication.*

****Please be sure to inform your Physical Therapist prior to treatment if you are pregnant, taking any medication that will thin blood, using long-term steroids or immunosuppressant medications, or have an implanted medical device.****

I have reviewed the above information and understand the risks and benefits associated with dry needling. It is my desire to pursue treatment, including dry needling, and I give my consent. This consent is valid for 1 year unless revoked in writing.

Signature of Patient (*or Responsible Party*): ____ Date: _____________

Printed Name of Responsible Party (*if other than patient*): ____