ELEVATE
SPORTS THERAPY AND FITNESS

Patient Intake

Patient Name: _____ Email:_____
Street Address:_____ City:_____ State:_____ Zip: _____
Cell Phone: _____ Home Phone:_____
Marital Status: **S / M / D / W** Date of Birth:_____ Sex: **M / F**
Primary Care Physician: _____
What Practice? _____ Phone: _____
Employer: _____ City/State: _____
Date of Current Injury/Onset: _____ Work Related Injury? **Y/ N**
Automobile or Personal Injury? **Y/ N**
Please briefly describe what you are seeking treatment for: _____
_____
Previous Treatments? Physical Therapy? **Y/ N** Chiropractic? **Y/ N** Acupuncture? **Y/ N**
If yes, When/Where and was it successful? _____
Are you represented by an attorney regarding this injury? **Y/ N** if yes, who? _____
Emergency Contact/Relationship: _____ Phone: _____
How did you hear about Elevate Therapy, PLLC? _____

Informed Consent

By signing below, the patient gives permission for the physical therapy evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from the treatment(s). I understand the term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that I will receive education concerning the diagnosis, treatment, and prognosis including anticipated goals at the initial visit. I will also be explained my plan of treatment and the options available for my condition at that time.

Use and Disclosure of Your Health Information/Privacy Practices

Your health information will only be used or disclosed by Elevate Therapy, PLLC for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice including my administrative operations related to treatment or payment.

--Email—
Elevate Therapy, PLLC may use my email to send occasional company newsletters containing relevant medical/rehab news and updates, deals or promotions. Email addresses will never be used by or given to 3rd parties for use outside Elevate Therapy, PLLC. You may opt out at any time.

Payment

Cancellation of a scheduled appointment must be done at least 48 hours prior to the appointment time to avoid a fee consisting of the full cost of the treatment session. A co-pay may be required prior to services depending on your particular insurance requirements

I have reviewed this consent form and acknowledge that the information I provided is true and that I agree to the terms outlined. I have been given the opportunity to review this form and ask any questions related to it. I give my permission to Elevate Therapy, PLLC to use and disclose my health information in accordance with it.

_____

Please print your name

_____ _____

Signature Date

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Name:_____ Date: _____ DOB: _____

Have you ever been diagnosed with any of the following? If "Yes", please explain in the space.

DISEASE PROCESSES:

Cancer	NO	YES	_____
Diabetes Mellitus	NO	YES	_____
High Blood Pressure	NO	YES	_____
Arthritis	NO	YES	_____
Osteoporosis	NO	YES	_____
Seizures	NO	YES	_____
Coronary Artery Disease	NO	YES	_____
Atherosclerosis	NO	YES	_____
Heart of Vascular Disease	NO	YES	_____

CURRENT HEALTH / MEDICAL CONDITIONS:

Do you have chest pain?	NO	YES	_____
Have you ever had any stroke(s)?	NO	YES	_____
Do you have a Pacemaker?	NO	YES	_____
Do you have breathing problems?	NO	YES	_____
Do you have frequent headaches/migraines	NO	YES	_____
Unexplained nausea/vomiting?	NO	YES	_____
Unexplained fever, night sweats?	NO	YES	_____
Do you routinely have pain while sleeping?	NO	YES	_____
Unexplained weight loss?	NO	YES	_____
Changes in bowel or bladder function?	NO	YES	_____
Dizziness/Vertigo?	NO	YES	_____
Numbness/tingling in the face or groin area	NO	YES	_____
Sudden changes in vision?	NO	YES	_____
Difficulty swallowing?	NO	YES	_____
Unexplained blackouts?	NO	YES	_____
Urinary tract infection less than 1 month ago	NO	YES	_____
Are you currently pregnant?	NO	YES	_____

SOCIAL HISTORY:

Do you smoke	NO	YES	_____
Have you recently suffered trauma from a fall, car accident, sports, etc.?	NO	YES	_____

Do you have problems with the following?

Hearing?	NO	YES	Communication?	NO	YES
Speech?	NO	YES	Reading?	NO	YES
Vision?	NO	YES	Writing?	NO	YES

Please list your surgical history, including dates (if any):

_____

_____

Medications you are currently taking (if any): _____

_____

_____

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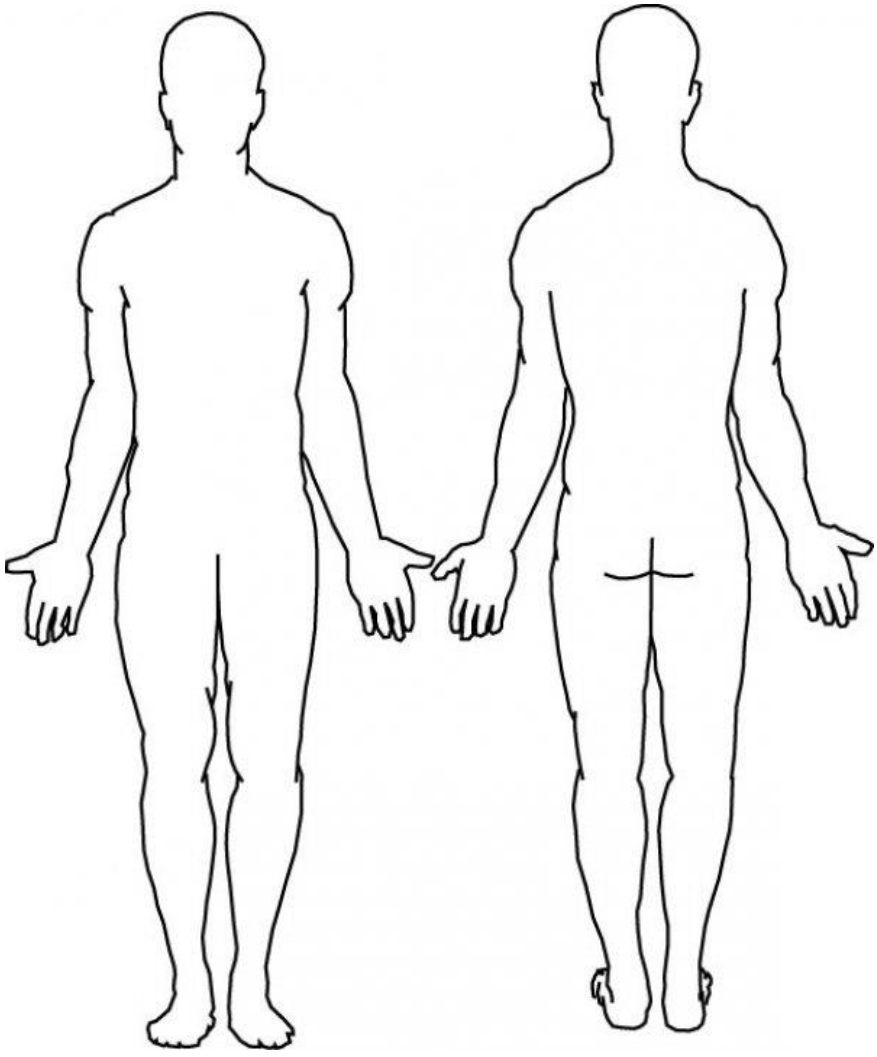
Name: _____ Date:_____ DOB: _____

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe the pain. Do not indicate areas of pain which are not related to your present injury or condition.

Key

/// Stabbing XXX Burning 000 Pins and Needles === Numbness ZZZ Aching



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Dry Needling (DN) Consent Form

Dry Needling involves placing a small needle into myofascial trigger points 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. Dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in orthopedic conditions.

Like any treatment there are possible complications. While these complications are rare in occurrences, they are real and must be considered prior to giving consent to treatment.

Risk of the procedure:

Dry needling is very safe; however serious side effects can occur in less that 1 per 10,000 (0.01%). The most serious risk associated with DN is accidental puncture of lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a very rare complication and in skilled hands should not be a concern.
Other risks may include infection or damage to internal organs. These are extremely rare events and have been reported in medical literature to occur in less than 1 in 200,000. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from DN is unlikely. Only single use, disposable needles will be used.
You should expect some temporary mild soreness post needling. Minor bruising may occur and is considered normal. The feeling of drowsiness, tiredness, or dizziness may occur following needling but is rare (1-3%) of patients.

You practitioner needs to know:

Have you ever fainted or experienced a seizure? **Yes** **No**
Do you have Hepatitis B, Hepatitis C, HIV, or any other infectious disease? **Yes** **No**
Do you have any know disease or infection that can be transmitted through bodily fluids? **Yes** **No**
Do you have any allergies to metals? **Yes** **No**
Do you have a pacemaker or other electrical implant? **Yes** **No**
Are you currently taking a blood thinner (i.e. Warfarin, Coumadin)? **Yes** **No**
Are you currently taking antibiotics for infection? **Yes** **No**
Have you had any form of surgery in the past 3 months? **Yes** **No**
Are you diabetic or suffer from impaired wound healing? **Yes** **No**
Are you currently pregnant or trying to get pregnant? **Yes** **No**

- DN is contraindicated while pregnant. I understand that if I am pregnant, suspect that I may be pregnant or become pregnant during the course of treatment, that I am responsible to inform the practitioner. _____ (Initial)

If you marked yes to any of the above, please discuss with your practitioner.
By signing below you hereby agree that the above information is correct and that you consent to receive dry needling treatments. Elevate Therapy, PLLC has your best interest and safety in mind.

Signature: _____

Print name:_____ Date: _____