OFFICE USE ONLY

SCANNED: ________ CO-PAY: ________

ACIPCO: ☐ EE ☐ DEPENDENT | ☐ WC

Patient Intake Form

Name: ____ Date: _____/_____/_________

Date of Birth: _____/_____/_________ Marital Status: ______________ SSN: __________________

Address: ____

City: ______________________________________ State: ________ Zip Code: _____________

Phone: (_______)____________________ ☐Cell ☐ Home Work Phone: (_______)_________________

Email: __________________________________ Primary Physician: ________________________

Occupation: ______________________________ Or ☐ Student Work Status: ___________________

Emergency Contact/Relationship: ____

Insurance Company: _______________________________ Policy Number: ____________________

Primary Insured Name: _______________________________________

Date of Birth: _____/_____/_________ SSN: _________________ Phone: (______)_________________

Address *(if different from above)*: ____

City: ______________________________________ State: ________ Zip Code: _____________

Secondary Insurance: ______________________________ Policy Number: ____________________

Primary Insured Name *(if different from above)*: _______________________________________

Date of Birth: _____/_____/_________ SSN: _________________ Phone: (______)_________________

Address *(if different from above)*: ____

City: ______________________________________ State: ________ Zip Code: _____________

Employer's Name: _________________________ Employer's Address: ___________________________

City: ______________________________________ State: ________ Zip Code: _____________

Case of Current Issue: ☐Auto Accident ☐Work Injury ☐Sports ☐Gradual Onset ☐Other: _______________

If auto or work accident:

Claim Manager/Adjustor's Name: ________________________ Company Name: ___________________

Phone Number: (_______)____________________ Fax Number: (_______)_____________________

Where did the injury/symptoms take place? __________________________ Date of Injury: ___/___/_____

Explain in detail how the injury/accident happened: _______________________________________

____

Did you have surgery for this injury? ______ Date of Surgery: _____/_____/_________

Type of Surgery: ____

Referring Physician: ______________________________ Return to Physician Date: ____/____/_________

Have you had physical therapy this calendar year? ______ If yes, how many visits? ____________

Are you on modified duty related to this injury? ☐Yes ☐No

Patient Medical History

Have you EVER been diagnosed with any of the following conditions?

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disorder
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Disease
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Smoking
- ☐ Speech Problems
- ☐ Strokes
- ☐ Thyroid Diseases
- ☐ Tuberculosis
- ☐ Vision Problems

Other: ____

____

Fall History: ☐ 2 or more falls in last year ☐ Injury as result of the fall

What type of injury? ____

Surgery History ***(Type and Date)***: ____

Current Medications ***(if you have an Rx list, we can copy it)***: ____

____

Medication Allergies: ____

____

Payment Information

☐ I understand that I am responsible for all charges that are allowed but not covered by my insurance company. I also understand that I am responsible for all deductibles, co-payments, co-insurances and supply purchases. It is my responsibility to keep track of my insurance coverage including but not limited to deductibles, co-payments, co-insurances, visit limitations and maximums.

Patient Name ***(printed)***: ____ **Date:** ____/____/________

Patient Signature: ____

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Joint Notice of Privacy Practices Acknowledgement

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies:

1. how medical information about you may be used or disclosed;
2. your rights to access your medical information, amend your medical information, request an accounting of disclosures of that information;
3. your rights to complain if you believe your privacy rights have been violated; and
4. our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the HIPAA Notice of Privacy Practices and is the patient, or the patient's personal representative.

☐ Patient agrees to release medical and or other information necessary to process claim.

☐ Patient authorizes payment of medical benefits to Iron City Physical Therapy.

☐ Patient grants permission for clinic to leave message on their voicemail.

☐ Patient grants permission to discuss their medical condition with other individuals.
Please list these individuals and their relationship to the patient below:

____

____

____

Name of Patient: ____________________________________

Patient Signature: ____________________________________ **Date:** ____/____/________

Patient's Representative: ____________________________________

Representative's Signature: ____________________________________ **Date:** ____/____/________

Dry Needling Information & Consent Form

Dry needling is an effective and valuable treatment for musculoskeletal pain. The procedure involves inserting a tiny monofilament needle into a muscle(s). This is done to decrease trigger point activity and release shortened bands of muscles. This process can help resolve pain and muscle tension, and will help promote healing. Dry needling is a medical treatment that relies on a medical diagnosis to be effective and is not traditional Chinese acupuncture. As with any treatment, there are possible side effects or complications. While complications rarely occur, they are real and must be considered before giving consent for treatment. Soreness is common and typically lasts 24-48 hours. Increasing your water intake for the next 24 hours is highly recommended.

Risks: With dry needling, the most serious risk is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms are shortness of breath, which may last for several days to weeks. **If you feel light headed or experience difficulty breathing, chest pain, or any other unusual or concerning symptoms after treatment, contact us immediately. If you are unable to reach us, please call your physician.** If a more severe puncture occurs, it may require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing minor bruising.

Patient's Consent: I understand that no guarantee or assurance has been given as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed. This consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Payment: I consent to a $50.00 charge for Dry Needling intervention, which will be collected at the end of the PT session. I understand that, unless specified as a self-pay charge, my insurance may not cover the full cost of dry needling; in which case, I, the patient, will assume full responsibility of the remaining cost per session up to $50.00.

Please answer the following questions:

1. Do you have a needle phobia or fear of needles? ❒ Yes ❒ No
2. Do you have a pacemaker or any other electrical implants? ❒ Yes ❒ No
3. Are you currently taking anticoagulants (ex: Aspirin, blood thinners)? ❒ Yes ❒ No
4. Are you currently taking antibiotics for an infection? ❒ Yes ❒ No
5. Are you pregnant? ❒ Yes ❒ No
6. Do you have a damaged heart valve, metal, or other risk of infection? ❒ 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, C, HIV, or any other infectious disease? ❒ Yes ❒ No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.
You have the right to withdraw consent for this procedure at any time before it is performed.

____ **Date:** _____/_____/_________
Patient or Authorized Representative Signature

______________________________________ ______________________________
Relationship to patient (if other than patient) **Patient Named (printed)**

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consent to its performance.

____ **Date:** _____/_____/_________
Physical Therapist