INFORMED CONSENT FOR PHYSICAL THERAPY EVALUATION AND TREATMENT

Patient Name: (Last) _____ **(First)** _____

Phone Number: _____ **Email:** _____

CONSENT FOR TREATMENT

I, (listed above) authorize the staff at Precision Health and Fitness to evaluate and begin treatment and procedures deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Precision Health and Fitness as to the results of treatments or interventions performed. Treatment may consist of but is not limited to manual techniques, therapeutic exercises, therapeutic activities, neuromuscular re-education, dry needling, and other techniques deemed appropriate for the condition being treated. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may be affected. Persistent refusal to participate or cooperate in the recommended treatment may result in my discharge from the program.

I hereby certify that I have read the contents of this Informed Consents and Release of Liability. I may request a signed copy of the Agreement and the Informed Consent. I agree to be bound by the reasonable rules and regulations adopted by Precision Health, Fitness & Performance, LLC in connection with the use of its facilities and equipment. I agree that the foregoing obligations shall be binding of me personally, as well as upon my family and my heirs, executors, administrators and assigns.

☐ I authorize Precision Health and Fitness to electronically send photos of home exercise programs, which will not be shared with anyone aside from the client.

PRECISION HEALTH & FITNESS INSURANCE POLICY

NO INSURANCE

☐ I do not have health insurance and will be responsible for the payment of any amounts owed to Precision Health and Fitness for physical therapy services, maintenance exercise programs and products provided.

PRIVATE HEALTH INSURANCE

☐ I have health insurance (HMO, PPO, etc), but I have been informed that Precision Health and Fitness are not participating providers with any health insurance. I understand that my health insurance will not be billed by Precision and that I will be billed at Precision's physical therapy visit's usual rate. I will be responsible for a *full* payment of that bill at the time of service. I understand that upon request, I will receive a bill from Precision for my physical therapy services that I can submit that bill to my health insurance company for reimbursement if I choose to do so (excludes Medicare and Medicaid insurances). Precision does not guarantee that my health insurance company will reimburse me for their physical therapy services. It is the patient's responsibility to contact their insurance and check for out-of-network benefits and whether or not pre-authorization is required.

CANCELLATION POLICY: 24 HOURS NOTICE

Precision takes training and therapy very seriously. Your time is very important and so is ours. Our staff will make every effort to let you know about appointment changes with at least twenty four (24) hours notice. We request that you do the same. In the event that you do not give twenty four (24) hours notice about an appointment change, you will be charged in full for your appointment.

Patient Signature: _____ **Date:** _____

Parent Signature: (If Patient is under age of 18) _____ **Date:** _____

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MEDICAL HISTORY/SUBJECTIVE INFORMATION (PAGE 1)

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Today's Date: _____

Name _____ **Birthday** _____ **Age** _____

Height _____ **Weight** _____ **Do you smoke?** ☐ **YES** ☐ **NO**

Who referred you to Physical Therapy?

For your current injury or condition, have you seen any of the following?
(Please check all that apply and specify approximate dates of treatment)

☐ Medical Doctor ☐ Physical Therapist ☐ Psychiatrist / Psychologist ☐ Dentist ☐ Osteopathic Doctor ☐ Chiropractor

Have you had any surgery for your injury/condition? ☐ YES ☐ NO

If yes, what kind and when? _____

Have you received any injections for your injury/condition? ☐ YES ☐ NO When? _____

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ YES	☐ NO	**Epilepsy**	☐ YES	☐ NO	**Arthritis**	☐ YES	☐ NO
Heart Condition	☐ YES	☐ NO	**Stroke**	☐ YES	☐ NO	**Hepatitis**	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	**Diabetes**	☐ YES	☐ NO	**Other**		

List any medications you are taking: _____

List any diagnostic tests that you've had for this condition: _____

How did your pain/injury occur? _____

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide exact dates)

First Episode _____ Most Recent Episode _____

IS YOUR PAIN: ☐ Getting **BETTER** ☐ Getting **WORSE** ☐ Staying the **SAME**
☐ **Constant** ☐ **Intermittent**

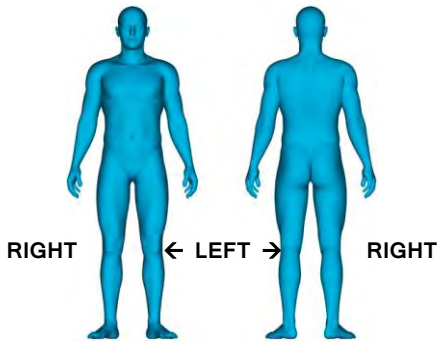
Please complete the items below using a 0-10 Pain Scale (0=No Pain; 10=Extreme Pain)

WORST Pain thus far: _____ **BEST Pain thus far:** _____

TODAY'S Pain _____ **TYPICAL Pain thus far:** _____

To be completed when you arrive:
Please mark the areas where you feel pain in the diagram below.
Mark the following:

- Constant Pain with a CIRCLE
- Tingling Pain with DOTS
- Sharp Pain with an X



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MEDICAL HISTORY/SUBJECTIVE INFORMATION (PAGE 2)

A complete medical history is necessary for a thorough evaluation. Please answer the following questions. Please look at the list below and indicate how your injury or condition has affected you daily. Circle the number the best applies to your ability to function.

Please circle your responses below:
1 = No Problem
2 = Can Do With Some Difficulty
3 = Can Do With Great Difficulty
4 = Cannot Do

SITTING	☐ 1	☐ 2	☐ 3	☐ 4
STANDING	☐ 1	☐ 2	☐ 3	☐ 4
SQUATTING	☐ 1	☐ 2	☐ 3	☐ 4
GOING UP/DOWN STAIRS	☐ 1	☐ 2	☐ 3	☐ 4
WALKING	☐ 1	☐ 2	☐ 3	☐ 4
TRANSFERRING POSITIONS (SITTING TO STANDING ETC.)	☐ 1	☐ 2	☐ 3	☐ 4
SPORTS/RECREATION (RUNNING/GOLFING ETC.)	☐ 1	☐ 2	☐ 3	☐ 4
DRIVING A VEHICLE	☐ 1	☐ 2	☐ 3	☐ 4
LYING DOWN	☐ 1	☐ 2	☐ 3	☐ 4
SLEEPING AT NIGHT	☐ 1	☐ 2	☐ 3	☐ 4
LIFTING/CARRYING (GROCERIES/BRIEFCASES ETC.)	☐ 1	☐ 2	☐ 3	☐ 4
GETTING DRESSED	☐ 1	☐ 2	☐ 3	☐ 4
DAILY JOB ACTIVITIES	☐ 1	☐ 2	☐ 3	☐ 4
HOUSEWORK OR YARDWORK	☐ 1	☐ 2	☐ 3	☐ 4
REACHING (OVERHEAD, BEHIND BACK, ETC.)	☐ 1	☐ 2	☐ 3	☐ 4
GRIPPING	☐ 1	☐ 2	☐ 3	☐ 4
FLEXING/EXTENDING ARM OR ELBOW	☐ 1	☐ 2	☐ 3	☐ 4
MOVEMENT OF MOUTH/JAW	☐ 1	☐ 2	☐ 3	☐ 4
SEXUAL ACTIVITY	☐ 1	☐ 2	☐ 3	☐ 4
OTHER:	☐ 1	☐ 2	☐ 3	☐ 4

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Dry Needling Consent Form

Intramuscular Manual Therapy Consent Form

IMT involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

IMT is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risks of the procedure:
Though unlikely there are risks associated with this treatment. The most serious risk associated with IMT is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and 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 rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT provider. If a pneumothorax is suspected you should seek medical attention from your physician or if necessary go to the emergency room.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily fluids? ___Yes ___No
If you marked yes, please discuss with your practitioner and/or document below.

_____ _____
Signature Date

_____
Name (Please Print)