COMPLETE ALL SECTIONS EITHER IN PRINT OR TYPE

A	PATIENT INFORMATION	Today's Date

Patient's Name _____ Birth Date _____

SSN _____ Gender _____

Home Address _____ City _____ State _____ Zip _____

Emp. / Occ. _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Referring provider _____ Primary Care Doctor _____

Home Phone _____ Cell Phone _____

Work Phone _____ Primary E-mail Address _____

Are you Pregnant? □Yes □No Marital Status: □Married □Single □Divorced □Widowed

If married, Spouse's Name _____ Spouse's Phone Number _____

Emergency Contact's Name _____ Phone Number _____

Emergency Contact's Relationship to Patient _____

How did you hear about us? □Yelp □Google □Facebook □Friend

B HEALTH INSURANCE INFORMATION – WE WILL NEED A COPY OF YOUR CARD AND ID

PRIMARY Insurance Company _____ Policy # _____ Group # _____

Responsible Party *(If different from patient)*:

Full Name _____ SSN _____ Date of Birth _____

□ Auto injury □ Worker's Comp

Claim # _____ Date of Accident or Injury _____

SECONDARY Insurance Company _____ Policy # _____ Group # _____

Responsible Party *(If different from patient)*:

Full Name _____ SSN _____ Date of Birth _____

C MEDICAL HISTORY

Do you take Coumadin (blood thinner) □Yes □No If yes, why? _____

Do you take any other anticoagulation medicine? □Yes □No If yes, why? _____

Allergies: (list any medications you are allergic to or react to) If none, please state "none"

_____

Are you allergic to latex? □Yes □No

In the past, have you received any blocks or injections for this problem? □Yes □No

List Type(s) if known: _____

Who administered the procedure? _____ Date received: _____

Currently, what is your major complaint? _____

Other complaints: _____

When did this condition begin? _____ How? _____

Have you ever had this problem or a similar problem before? _____

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Have you lost work days? □Yes □No If yes, how many days? _____

Have you returned to your same job? □Yes □No If not, why? _____

Has this problem been getting □better □worse □staying the same?

What makes the pain worse?_____

What makes the pain better?_____

Does the pain travel from its site to anywhere else in your body?_____

What kind of pain do you have?

□throbbing □aching □burning □dull □achy □sharp □other:_____

Rate the pain 1- 10 (1 least, 10 worst) ___

What time of day does the pain occur? _____

Does the pain wake you up? □Yes □No

Is the pain constant? □Yes □No

Have you received any treatment for this condition? □Yes □No

If yes, where, when and what were the results? _____

Please list ALL medications. If unable to, please provide a copy of your current medications history

_____

Please list any surgeries or hospitalizations _____

_____

Past diagnosis: Please provide any diseases/medical conditions diagnosed by medical professionals

_____

Average hours of sleep ____/ night Alcohol:□Yes □No Tobacco: □Yes □No Exercise ____/ week

Hobbies: _____

Present Conditions: Mark (x) to all that apply.

_Headache	_Dizziness	_Neck pain/stiffness	_Shoulder pain/stiffness
_Upper/mid back pain	_Low back pain/stiffness	_Hip pain	_Numbness in finger/toe
_Pins/needles in arm/leg	_Sleeping problems	_Depression	_Nervousness
_Cancer	_Fatigue	_Chest pain	_Light bothers eyes
_Loss of memory	_Flushed face	_Loss of balance	_Fainting spells
_Loss of smell	_Loss of taste	_Diarrhea/constipation	_Cold hands/feet
_Upset stomach	_Cold Sweats	_Fever	_Stroke
_Heavy head	_Chest pain	_Shortness of breath	_AIDS
_Buzzing/ringing in ears	_High blood pressure	_Low blood pressure	_Diabetes

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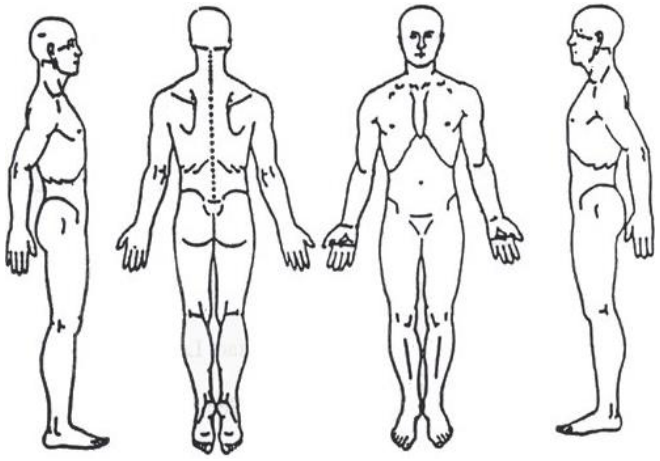
D PAIN DIAGRAM

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

o Numbness o × Pins/Needles × ★ Burning★ +Aching + ✓ Stabbing ✓



Mark the following scale for your CURRENT level of pain

No Pain ⟷ Unbearable Pain

Patient Signature _____ Date _____

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Trigger Point Dry Needling (TDN) Consent Form

Trigger point Dry Needling involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. TDN is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered 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 TDN 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. 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 rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. 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 TDN is unlikely.

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

Do you have any known diseases that can be transmitted through bodily fluids? □ YES □ NO

If you marked YES, please discuss with your practitioner.

□ I understand that the practitioner applying this technique has fully completed training in trigger point dry needling fulfilling all the requirements set forth by the state of Colorado Department of Regulatory Agencies.

Consent for Treatment for TDN

I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**, if necessary.

I hereby authorize **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I understand that physical therapy requires physical contact.

Print Patient's Name _____

Patient/Guardian Signature _____

Date _____

□ I was offered a copy of this consent and refused TDN

Assignment of Benefits

1.) I agree to be responsible for payment of ALL SERVICES RENDERED on MY (or my dependents') behalf. I understand that payment is due AT THE TIME OF SERVICE.

2.) I hereby authorize my insurance benefits to be paid directly to **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy).** I realize I am financially responsible for NON-COVERED SERVICES (such as deductibles, claims denied, canceled insurance, etc.)

Print Patient's Name _____

COMPLETE ALL SECTIONS EITHER IN PRINT OR TYPE

Patient/Guardian Signature _____
Date _____

Cupping Therapy Consent Form

Cupping therapy is an ancient form of alternative medicine in which a therapist puts special cups on your skin over ten minutes to create suction. People get it for many purposes, including to help with pain, inflammation, blood flow, relaxation and well-being, and as a type of deep-tissue massage and myofascial release.

Cupping can cause temporary pain and bruising may occur. Bruising may last for several days.

Please notify our clinic if you are taking any medication that might interfere with the procedure.

By signing your name, you are consenting to getting cupping done with **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)**.

Print Patient's Name _____
Patient/Guardian Signature _____
Date _____

Consent for Treatment

I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** if necessary.

I hereby authorize **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy)** to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I understand that **J Medical Inc., DBA (Therahand Physical Therapy/ Therahand Wellness Center/Foundation Physical Therapy) requires physical contact**.

Print Patient's Name _____
Patient/Guardian Signature _____
Date _____

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Cancellation Policy
All cancellations **must be cancelled in at least 24 hours before the scheduled appointment** or a cancellation fee of **$70.00 will be charged**.

NO SHOW/ NO CALL WILL BE CHARGED $100.00.

□ I have read and understand the cancellation policy.

During physical therapy treatment, individual exercises will take place in an "open gym" with other patients present. As our clinic has an "open gym", if you are sick or in a poor health condition that may possibly be contagious, please call in to cancel your appointment or make rearrangements.

I have read and understand the "open gym" policy.

Our clinic has the right to refuse a person(s) from treatment due to factors such as severe patient health condition or inappropriate behavior and language that may cause disturbance to the practice as well as the other patients'.

Thank you for your cooperation.

Print Patient's Name _____
Patient/Guardian Signature _____
Date _____