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**PATIENT EVALUATION AND CONSENT FORM**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Last First (Legal) Initial

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/Week: \_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Next Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialist Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Next Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer yes or no to the following questions.**

Have you ever fainted? \_\_\_\_\_ Are you pregnant or actively trying for a pregnancy?\_\_\_\_\_\_

Have you ever had a seizure? \_\_\_\_\_ Do you suffer from metal allergies? \_\_\_\_\_\_

Do you have a pacemaker or any other electrical implant? \_\_\_\_\_ Are you diabetic or suffer from impaired wound healing? \_\_\_\_\_

Are you currently taking anticoagulants (i.e. aspirin, warfarin, Coumadin)? \_\_\_\_\_\_ Are you currently taking antibiotics for an infection?\_\_\_\_\_\_

Do you have Hepatitis B/C, HIV, or any other infectious disease?\_\_\_\_\_ Have you eaten in the last 2 hours? \_\_\_\_\_\_

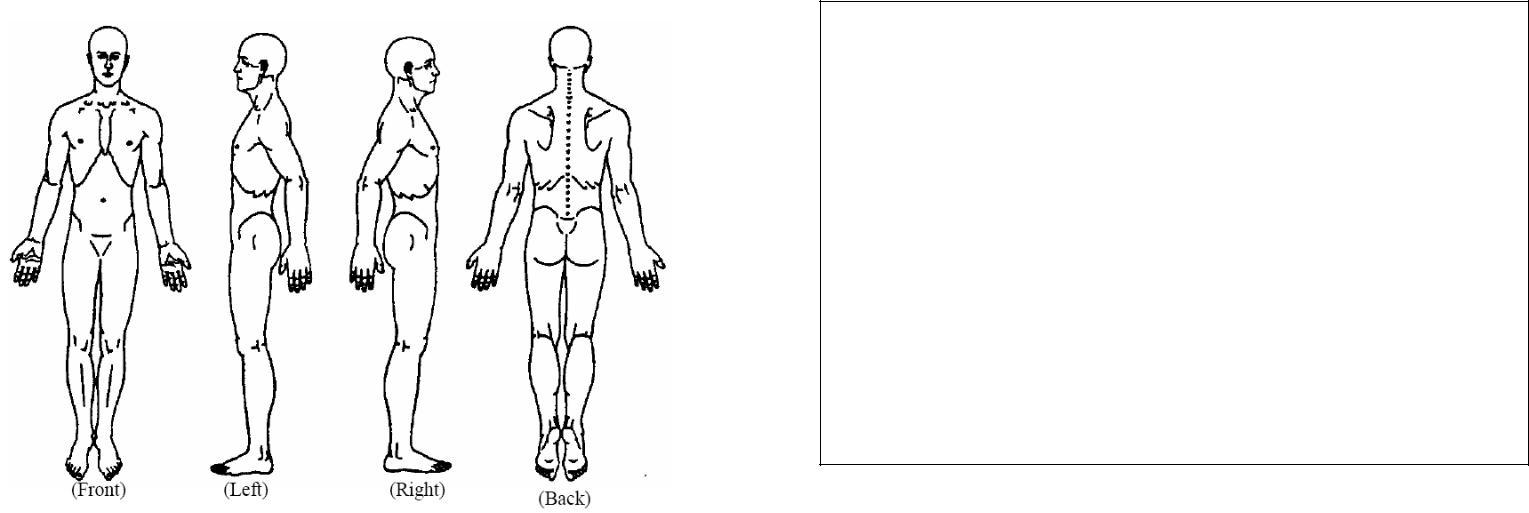
Do you have a damaged heart valve, metal prosthesis or other risk of infection? \_\_\_\_\_

**Please complete this brief health questionnaire.**

Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was the Onset:  Gradual  Sudden Since onset, is it:  Worse  Better

Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary or related complaint (if any) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE MARK WHERE YOUR PAIN IS LOCATED:

**SEVERITY OF PAIN:**

Circle the number that represents the intensity of your pain.

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10  
 no pain unbearable

Best Pain Level 0 1 2 3 4 5 6 7 8 9 10  
 no pain unbearable

Worst Pain Level 0 1 2 3 4 5 6 7 8 9 10  
 no pain unbearable

Describe what caused the pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the quality of the complaint/pain: sharp dull/ache throbbing tingling/numbness  other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle if any of the following make the pain worse: lifting bending pushing pulling coughing sneezing bowel movement

driving riding sitting walking running standing

other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe if pain is in a single spot or does it spread out:  radiating dull  deep ache  pin point  burning  sharp

 stabbing  tingling  numb  other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does any of the following make it better:  rest  laying down  sitting  walking  exercise  other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
How often are you aware of the pain:  intermittent (Less than 25% of time when awake)  occasional (25-50%of time when awake)

frequent (50-75% of time when awake)  constant (75-100% of time when awake)



Does it interfere with your daily activities:  minimal (annoyance, no impairment)  slight (tolerated, some impairment)

 frequent (marked impairment)  constant ( precludes any activity)

Have you detected any possible relationship of your current complaint with any of the following?

 Muscle Weakness  Bowel/Bladder problems  Digestion  Cardiac/Respiratory Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried any self-treatment or taken any medication (over the counter or prescription):  Yes  No

If yes, explain; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Health and Social History:**

Is this the first time you have experienced this problem?  Yes  No If no, When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Was treatment provided?  Yes  No If yes, By whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, or surgeries?** If yes, please list below.

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | **INJURY/FRACTURE/ILLNESS** | **TREATMENT** | **RESULTS** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

What is your approximate height? \_\_\_\_\_\_\_\_\_ What is your approximate weight.?\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly exercise?  Yes  No If yes, how many hours a week and what activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?  None  Light  Moderate  Heavy How many glasses per week? \_\_\_\_\_\_\_\_\_

Check any conditions you have had:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AIDS/HIV | Deafness | Heart Disease | Osteoporosis | Thyroid Problems |
| Allergies | Diabetes | Herniated Disc | Poor Circulation | TMJ |
| Anxiety/Depression | Digestion Problems | High blood pressure | Prostrate Problems | Venereal disease |
| Arm/shoulder pain | Earache | Insomnia | Rheumatoid | Vertigo/Dizziness |
| Arthritis | Ear ringing | Irregular Cycle | Arthritis | Other: |
| Asthma | Epilepsy | Kidney Problems | Sciatica | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Bladder Problems | Headaches | Leg Pain | Shingles | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cancer | Headache –Migraine | Low back pain | Sinus Infections | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Chronic Fatigue |  | Neck Pain | Stroke |  |

Please provide any additional information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications and supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please read carefully and sign the consent form below before examination and treatment.**

Thank you for choosing to seek physical therapy services from *In Motion Physical Therapy, PLLC*. *In Motion Physical Therapy, PLLC* implements evidence-based practice by incorporating clinical research, physical therapist's clinical experience, and your preference for treatments to provide the best chance for having success in minimizing or stopping the problems you are having.

This release is entered into between myself \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and *In Motion Physical Therapy, PLLC*.  
 (Your Name)

I fully understand and acknowledge that any or all of the following treatments and or activities in which I will engage in as part of a physical therapy plan of care include but are not limited to: spinal manipulative therapy, dry needling, spinal mobilization, extremity manipulative therapy, physical therapy, rehabilitative therapeutic massage, cupping, instrument assisted soft tissue mobilization, exercise, personal training and nutrition counseling. I understand that In Motion Physical Therapy, PLLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

**Dry Needling:** Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful neuromusculoskeletal conditions. Dry needling is not acupuncture or Traditional Chinese/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 disease. In fact, dry needling is a modern science-based intervention for the treatment of pain and dysfunction in muscle and bone conditions such as but not limited to: neck pain, back pain, headaches, tennis elbow, shoulder impingement, knee pain, plantar fasciitis, and carpal tunnel syndrome.

Drowsiness, tiredness or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a “bad” sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck region. Dry needling is very safe; however, serious side effects can occurs in less than 1 per 10,000 (less than 0.2%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment sessions, sometimes taking several hours to develop. The signs and symptoms of pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

**Treatment results:** I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of physical therapy is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my physical therapist and such other person of the physical therapists choosing.

**Medications:** Medication can be used to reduce pain or inflammation. I am aware that long-term use of overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** I also understand that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited benefit and are not corrective of injured nerve or joint issues.

**Non-treatment:** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I understand the inherent risks, dangers, and hazards and such exist as part of my plan of care or activities in my use of any equipment and my participation in these activities. My participation in such treatment, activities and or use of such equipment may result in injury or illness including but not limited to bodily injury, disease, strained, fractures, partial and/or total paralysis, soreness, bruising, dizziness, nausea, stroke, electrical burns, death, or other ailments that could cause serious disability. These risks and dangers may be caused by the negligence of *In Motion Physical Therapy, PLLC,* the negligence of participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of representatives of *In Motion Physical Therapy, PLLC* or by any other person.

On behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify *In Motion Physical Therapy, PLLC* and their representatives and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives of *In Motion Physical Therapy, PLLC.*

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE IT IS MY INTENTION TO EXEMPT AND RELIEVE

IN MOTION PHYSICAL THERAPY, PLLC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian (if a minor) Date