Patient Data Sheet

MRN: _____ PN: _____

Patient Name: Last: _____ First: _____ MI: _____

Date of Birth: _____/_____/_____ Sex: M / F Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Nature of Problem: _____ Date of Injury/Accident/Surgery: _____/_____/_____

Previous Physical Therapy: _____ How many visits? _____

Responsible Party Information

Relation to Patient: Self _____ Spouse _____ Parent _____ Other _____

Name: Last: _____ First: _____ MI: _____

Date of Birth: _____/_____/_____

Insurance Information

PO Box: _____

Primary Insurance: _____ City/Phone: ( ) _____

Policy/Claim #: _____ Group #: _____

Secondary Insurance: _____ City/Phone: ( ) _____

Policy/Claim #: _____ Group #: _____

******Office Use Only******

Policy Effective Date: _____/_____/_____ Cal Year _____ Deductible _____ Amt of Deductible Met $ _____

Co-Ins. % _____ Co-pay $ _____ # Visits Auth: _____ Visits Used: _____

OOP $ _____ OOP Met $ _____ Referral Needed? Y / N Auth Needed? Y / N

Rep: _____ Ref # _____

Referring Physician: _____ ** **PANORAMA DOCTOR: YES / NO**

Start of Care Date: _____/_____/_____ Time: _____ Treating Therapist: _____

Patient Name: _____MRN: _____PN: _____

Medical History/Intake

Patient Name: _____DOB:_____ Age: _____

Emergency Contact/Relationship: _____ Phone #:_____

Family Physician: _____ Surgery: Yes / No If yes, date of surgery: _____

List all medication you are currently taking: _____

Are you allergic to: Medications Latex Adhesive Other:_____

Do you have or ever had? Yes

Cancer: _____	☐	Diabetes	☐	Osteoporosis	☐
Chest Pain (Angina)	☐	Vision/Hearing Problems	☐	Osteopenia	☐
Shortness of Breath	☐	Thyroid Disease	☐	Epilepsy/Seizure	☐
Night Sweats	☐	Fatigue	☐	Gout	☐
Pain that wakes you from sleep	☐	Depression	☐	Weakness	☐
Unexplained Weight Loss	☐	Emotional/Psychological Dx	☐	Do you smoke	☐
High Blood Pressure	☐	Bowel/Bladder Problems	☐	Are you pregnant	☐
Coronary Artery Disease	☐	Numbness/Tingling	☐	Recently given birth	☐
Heart Attack	☐	Joint Replacement	☐	Chemical dependency	☐
Blood Clot	☐	Pins or Metal Implants	☐	Eating disorder	☐
Stroke or TIA	☐	Foot/Ankle Injury/Surgery	☐	Anxiety/Panic attacks	☐
Do you have a pacemaker	☐	Knee Injury/Surgery	☐	Asthma/Breathing problems	☐
Irregular Heartbeat	☐	Neck or Back Injury/Surgery	☐	Pneumonia	☐
Anemia	☐	Shoulder Injury/Surgery	☐	Have you fallen this year	☐
Ulcer/Stomach problems	☐	Hepatitis	☐	HIV/AIDS	☐
High Cholesterol	☐	Varicose Veins	☐	Neuropathy	☐

Describe your symptoms: _____

Initial Onset Date: _____ How did your symptoms begin? _____

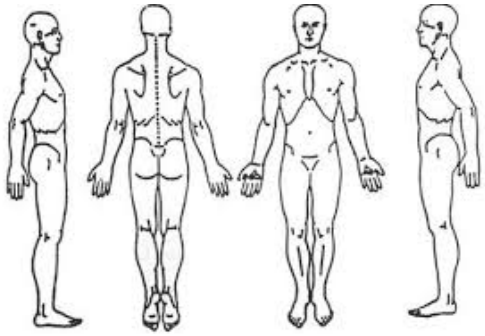
How often do you experience your symptoms?
① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

How are your symptoms changing?
① Getting better ② Not changing ③ Getting worse

How much have you symptoms interfered with your usual daily activities?
① Not at all ② A little bit ③ Moderately ④Quite a bit ⑤ Extremely

In general, would you say your overall health right now is…
① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Indicate where you have symptoms



Average Pain Intensity

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Patient Signature: _____ Date_____

Patient Name: _____MRN: _____ PN: _____

Orthopedic Rehabilitation Associates Cancellation/No Show Policy

And

Notice of Privacy Practices

The Staff at Orthopedic Rehabilitation Assocaites work hard to provide quality care and to give each patient the time required for their condition. We offer early morning and evening hours for those whose schedules do not allow treatment during the day.

As our business grows, it becomes increasingly important that we continue to offer treatment time slots that are as convenient as possible to our patients. It is equally important that if you wish to cancel or reschedule an appointment that we receive at least 24 hours notice so that we can call and schedule patients from our waiting list. We do realize that scheduling conflicts and emergency situations occasionally arise and we will do our best to excuse these special circumstances.

A $25 Cancellation/NO Show Fee will be charged to your directly. These fees cannot be billed to insurance.

A voice message on our phone is an acceptable means to communicate a cancellation within 24 hours of your scheduled appointment.

Thank you in advance for your consideration.

I have read and understand Orthopedic Rehabilitation Associates Cancellation/No Show Policy

_____ _____

Patient/Responsible Party Signature Date

Notice of Privacy Practices

I hereby acknowledge that I have read and received Orthopedic Rehabilitation Associates Notice of Privacy Practices.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Guardian Date

Dry Needling Consent & Information Form

What is 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 musculoskeletal conditions. Dry needling is not acupuncture. It does not have the purpose of altering the flow of energy (Qi) along meridians as in traditional Chinese medicine. Dry needling is a modern science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions.

Is dry needling safe?

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 for some patients (1-3%); however, this is not necessarily a "bad" sign. Fainting can occur in about 0.3% of patients, with increased incidence following the first treatment session in the head or neck region.

Dry needling is very safe. However, serious side effects can occur in less than can occur in less than 1 per 10,000 treatments (0.01%). The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of pneumothorax induced by dry needling commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of pneumothorax may include shortness of breath on exertion, increased rate of breathing, chest pain, dry cough, bluish skin discoloration or excessive sweating. If such signs and/or symptoms occur, you should immediately contact you physical therapist or physician. It is also possible that nerves or blood vessels may be damaged during dry needling which can result in pain, numbness or tingling. This is a rare event and is usually temporary. In addition, damage to internal organs has been reported in the medical literature following dry needling but this is also very rare (1 in 200,000).

Is there anything your physical therapist needs to know?

- Have you ever fainted or experienced a seizure? YES / NO
- Do you have a pacemaker or other electrical implants? YES / NO
- Are you currently taking anticoagulants (examples-Aspirin, Warfarin, Coumadin)? YES / NO
- Are you currently taking antibiotics for an infection? YES / NO
- Are you at increased risk of infection? YES / NO
- Are you pregnant or actively trying to become pregnant? YES / NO
- Do you have allergies to metals or latex? YES / NO
- Do you have diabetes or impaired wound healing? YES / NO
- Do you have hepatitis B, hepatitis C, HIV or any other bloodborne pathogens? YES / NO
- Do you have any silicone or saline implants? YES / NO
- Have you eaten today? YES / NO

Single-use, disposal needles are used at this clinic

STATEMENT OF CONSENT

I confirm that I have read and understand the above information and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

Printed Name: _____

Signature: _____ **Date:** _____

Patient 1-800-Notify COSENT FORM

Patient Name: **Patient #:** **Date:**
Date of Birth: (If patient is 18 or under, must supply Parent/Guardian Info)

Guardian/Parent Name: _____

In caring for our patients, it may be necessary for our practice to contact you by automated calls to leave a message or text. When you are not available to speak to directly, we like to leave messages when possible. In order to protect your privacy, it is our policy to not leave specific information on an answering machine/voice mail system, unless we have permission to do so.

Please check applicable way for us to reach you/leave messages for you.

[ ] **YES**, call me on this phone number and leave a voice mail: _____

[ ] **YES**, text me on this mobile phone number:_____(mobile phone)

[ ] **NO**, I do not give consent for you to leave a voice message or text me with appointment reminder through 1800 Notify.

If you have any questions please call us at the clinic.

I have the option to update and/or change my preferences of how to contact me at any time by completing a **NEW PATIENT 1-800-Notify CONSENT FORM** or otherwise putting my request in writing and submitting it back to the clinic.

Patient/Guardian signature: _____

Date: _____