DYNAMIC EDGE
PHYSIOTHERAPY
YOUR BODY, YOUR BEST.

PATIENT INTAKE

First Name: __________________________ MI: ______ Last Name: _____________________________________

Address: ____________________________________ City/State/Zip: ____________________________________

Date of Birth: _____ / _____ / _____ Gender: Male __ Female__

Email Address: ____

HomePhone: ____________________ Cell Phone: ________________________ Work Phone: _______________________

Emergency Contact Information:

Name: ____ Phone: ____________________________________

Address: ____ City/State/Zip: _______________________________

Occupational Information

Employer Name: ____

Address: ____ City/State/Zip:__________________________________

Days Per Week: _____________ Hours per Day: _______ Full-time: ______ Part-time: _______

Working with modification in job because of current illness/injury: Yes / No Not working because of current illness/injury:Yes / No

How did you hear about Dynamic Edge Physiotherapy? ____

Notice of Privacy Practices

I hereby acknowledge that I have been made aware of Dynamic Edge Physiotherapy's Privacy Practices (copy available at front desk or on the Dynamic Edge website.) I may request a copy of any amended Notice of Privacy Practices at any time.

Authorization to Release /Obtain Information

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Dynamic Edge PhysioTherapy. Further, I authorize Dynamic Edge Physiotherapy to obtain needed information from my physician, employer or insurance. This correspondence can be obtained via mailings, phone, fax or email.

Payment/Insurance Eligibility

Payment is due at the time of treatment. Verification of benefits is NOT a guarantee of payment. Payment is determined at the time a claim is received. We provide you with the information as it is outlined by your insurance company. **It is your responsibility to contact your insurance company to fully understand your benefits**. All unpaid & undisputed balances over 30 days will be charged to the credit card provided at registration. We reserve the right to charge interest on any balance that exceeds 30 days. In the event my account is referred to a third party for collection purposes, I will be responsible for all charges up to the statutory limit. **Returned Check Fee**: A $35 service fee will be charged for any returned checks.

Appointments / Cancellations

We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for a speedy recovery. We expect you to keep all of your appointments with Dynamic Edge Physiotherapy and require 24-hours notice if you are unable to keep an appointment. **Failure to cancel appointments within 24-hours will result in a $75.00 charge. No Shows will result in a $100 charge**. These charges will not be reimbursed by any insurance company.

Cell Phone Use

For your benefit, as well as others around you, please refrain from using your cell phone or other electronic devices during your physical therapy session.

Patient or Guardian's Signature ___________________________________ **Date**: ___/___/______

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PATIENT HEALTH HISTORY

Patient Name: ____

Initial Evaluation Date: ___________ Height : _________ Weight: __________

Do you have a prescription: Yes / No Referring Provider: ______________________________

Next MD Visit: ___/___/_____

Living arrangements:

Patient Owned/Rented (house/apt) ___

Family Member's Residence ___

Board and Care or Assisted Living ___

Other ______________________________

With whom do you live? (In order to better plan your care)

Alone ___ Spouse/Significant Other ___ Child/Children ___

Other Relative(s)___ Group setting ___ Other ___________

History of Present Conditions:

Current Complaints:

____

Body Part/Region: ____

When did your symptoms start (date) ___/___/____

____

If you are coming in due to an injury, how did you injure yourself? ______________________________________

Special orders from your Physician____

Have you seen anyone else for this problem? Please list____

If you are coming in after surgery, please explain____

Surgery Date: _____/_____/_____

PAIN:

Please describe your pain: (i.e.: Burning/stabbing/ache)____

Where is your pain located? ____

When is the pain at its worst? ___Morning ___Night ___With activity ___At rest

Please fill in the appropriate number for each of the below:

Rating: 0---------------------5-------------------10: Now?______At its Best?_____At its Worst?_______

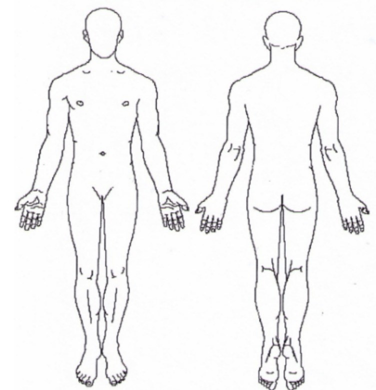
No Pain *Hospital*

Please draw your pain on the body to the right using the following symbols:

//// Stabbing pain **XXX** Burning **ooo** Pins and Needles **vvv** Numbness

Is the pain: Constant ___ On and off ____

Are your symptoms getting: Better___ Worse___ Staying the Same____



What makes your symptoms worse?____

What makes your symptoms better? ____

What activities do you have difficulty doing? ______________________________________

What previous activities do you want to resume? ___________________________________

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PAST MEDICAL HISTORY:

If you have had any of the following conditions please circle all that apply. If none of the below apply please check here____

Cancer
Lung Disease
Low Blood Sugar
Unusual Joint Pain/Swelling
Allergies
Emphysema/Bronchitis
Hepatitis
Kidney Disease

Heart Problems/Disease
Heartburn
Osteoporosis
History of Fractures
High Blood Pressure
Multiple Sclerosis
Other Arthritic Conditions
Anemia

Angina/Chest Pain
Thyroid Condition
Impaired Vision
Circulation Problems
Rheumatoid Arthritis
Tuberculosis
Epilepsy
Headache:
Increase in Frequency or Intensity

Diabetes
Impaired Hearing
Asthma
Depression
Stroke
Pregnant
Shortness of Breath

Have you recently noticed…?
Sudden unexplained weight loss/gain
Nausea/Vomiting
Weakness
Fever/Chills/Sweats
Numbness or Tingling

Do you use…?
Cane
Walker, Rolling Walker or Rollator?
Manual Wheelchair
Motorized Wheelchair
Other: ________________________

General Health Status:
Smoker
Obese
Alcohol Dependent
Drug Dependent
Patient's Self Report:

List all previous surgeries and approximate dates

PROCEDURE	DATE

List diagnostic tests for this problem (include X-rays,MRI, EMG,etc.)

TEST	DATE	RESULT

List current medications, dosage, and purpose (including over the counter): Check each day a dose is taken

MEDICATION	AMOUNT	TIME	SUN	MON	TUES	WED	THUR	FRI	SAT

If you need more space, please list on the back of this form.

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INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Dynamic Edge Physiotherapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name_________________________________**Signature**___________________________________ **Date**_________

FUNCTIONAL DRY NEEDLING® CONSENT AND REQUEST FOR PROCEDURE

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Your physical therapist trained by KinetaCore® has met requirements for competency in Functional Dry Needling® and is considered a certified Functional Dry Needling® Practitioner. All training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with FDN 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 of shortness of breath may last for several days to weeks. A more severe puncture can 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 a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made 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, thus 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.

Procedure: I, ______________________________________, authorize Dynamic Edge Physiotherapy to perform Functional Dry Needling® as part of my physical therapy treatment.

Please Answer the Following Questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No **Are you taking blood thinners?** Yes No

DO NOT SIGN UNLESS YOU HAVE READ & THOROUGHLY UNDERSTAND THIS INFORMATION.

You have the right to withdraw consent for this procedure at any time before it is performed.

Patient or Authorized Representative Signature____ **Date** ________________

Relationship to Patient (if other than patient) ____