

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Occupation & Employer: _____

Emergency Contact & Phone Number: _____

Primary Care Provider Name & Phone Number: _____

Insurance Information

Company: _____ Address: _____

Subscriber/Policy Number: _____ Group Number: _____

Insured Name: _____ DOB: _____ Relation: _____

Medical HistoryWhat is/are your main complaint(s)? ☐ Pain ☐ Numbness/Tingling ☐ Stiffness ☐ Dizziness
Balance loss ☐ Other: _____What body part are you here for today? _____ ☐ Left ☐ Right

When did this problem begin? _____

Was there a specific injury? ☐ Yes ☐ No (If yes, please describe): _____Have you ever had physical therapy for this problem? ☐ Yes ☐ NoHave you had physical therapy this calendar year? ☐ Yes ☐ NoIs your injury work related? ☐ Yes ☐ NoIs your injury related to a motor vehicle accident? ☐ Yes ☐ No

If you have pain, please rate on a scale of 0 to 10 (0 = no pain & 10 worse imaginable)

At this current time: /10 Worst in the past 24 hours: /10 Best in past 24 hours: /10

List any orthopedic surgeries that you have had: _____List any other surgeries that you have had: _____**Diagnostic Testing:** Have you had any of the following tests for your current problem:☐ X-ray ☐ MRI ☐ CT scan ☐ EMG/Nerve Conduction Study ☐ Other: _____

Results (if known): _____

Medical History: Please check any conditions that you have

- | | | |
|---|---|--|
| ☐ Diabetes | ☐ Stroke | ☐ TIA (mini stroke) |
| ☐ Heart Arrhythmia | ☐ Coronary Heart Disease | ☐ High BP |
| ☐ Heart Attack | ☐ High Cholesterol | ☐ Depression |
| ☐ Rheumatoid Arthritis | ☐ Liver Disease | ☐ Kidney Disease |
| ☐ Neuropathy | ☐ Acid Reflux | ☐ Osteoarthritis |
| ☐ Cancer Type: _____ | | |
| ☐ Other: _____ | | |
| ☐ I do not have any medical problems | | |

Are you allergic to latex? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Do you have a pacemaker or defibrillator? ☐ Yes ☐ No
Female Patients: Is there any possibility that you are pregnant? ☐ Yes ☐ No

Review of Systems: Are you currently having, or have you had, problems with: ☐ None
Bleeding Disorders? ☐ Yes ☐ No Heart or Chest Pain? ☐ Yes ☐ No GI Ulcers? ☐ Yes ☐ No
Numbness/Tingling? ☐ Yes ☐ No Lungs or Breathing? ☐ Yes ☐ No

Medications: Do you currently take any medications, vitamins, supplements or herbs:
☐ Yes ☐ No If yes, please provide a current list.

Goals: Please list the goal(s) that you hope to achieve by attending physical therapy: _____

HIPAA Privacy Acknowledgment

Connect Physical Therapy, PLLC is committed to protecting the privacy and confidentiality of your health information. Details about your condition, treatment, or any aspect of your care will only be shared with your explicit consent, unless otherwise permitted or required by law.

By signing below, I acknowledge that I have received and reviewed the Connect Physical Therapy, PLLC Privacy and HIPAA Policy. **(INITIALS REQUIRED)** _____

Financial Policy

I authorize payment of medical benefits directly to Connect Physical Therapy, PLLC for services provided. I understand that insurance coverage for physical therapy services may vary and that I am financially responsible for any charges not covered by my insurance plan.

I acknowledge that it is my responsibility to verify my physical therapy benefits with my insurance provider. I understand that Connect Physical Therapy, PLLC does not automatically check insurance coverage or benefits on my behalf.

Billing statements will be issued on the 1st of each month. If a balance becomes more than **90 days past due**, the account may be sent to collections.

I also acknowledge that if I fail to provide at least **4 hours' notice** to cancel or reschedule an appointment, or if I miss an appointment without notice, a **\$25 no-show/late cancellation fee** may be charged to my account. I understand this fee is **not billable to insurance**. **(INITIALS REQUIRED)** _____

Consent for Use of Image, Testimonial, and/or Video

I hereby authorize Connect Physical Therapy to take photographs, video recordings, and/or written or verbal testimonials of me and/or my treatment experience. I understand that these may be used for:

- Educational or informational purposes
- Marketing and advertising (including social media platforms and website)
- Patient or community engagement

I understand that:

- My name will NOT be used unless I give explicit permission.
- I may withdraw my consent at any time by providing written notice.
- This consent is voluntary and does not affect the care I receive at Connect Physical Therapy, PLLC.

Please Check One of the Following:

- ☐ I give full consent to the use of my photo/video/testimonial for marketing, educational, or promotional purposes, as described above.
- ☐ I give partial consent (please specify limitations): _____
- ☐ I do NOT give consent to use my photo/video/testimonial.

Consent to Care

Thank you for choosing Connect Physical Therapy, PLLC as your provider for physical therapy, health, and wellness services. By signing this form, you are providing consent for Connect Physical Therapy, PLLC to evaluate and treat you (or your family member) as requested.

By completing the intake form, I affirm that I have fully disclosed all relevant medical history that may influence, impact, or contraindicate treatment. I consent to receive physical therapy and/or wellness services that are deemed appropriate and medically necessary for my condition, illness, or injury, as determined by the licensed professionals at Connect Physical Therapy, PLLC.

I understand that Connect Physical Therapy, PLLC is a fully licensed facility, and that the treating therapists are qualified, trained, and committed to delivering safe, effective care. Although every effort will be made to ensure my safety, I acknowledge that all medical treatments carry some inherent risk, and that unforeseen complications may occur. I understand that reasonable precautions will be taken, and by signing this consent, I agree not to hold Connect Physical Therapy, PLLC liable for any unforeseen injury that may arise during the course of care. **(INITIALS REQUIRED)** _____

The above is true and correct to the best of my knowledge.

Patient Signature:

Date: _____

Parent/Guardian Signature (if patient a minor): _____

Dry Needling Consent (Complete Only If Recommended as Part of Your Treatment Plan)

This section is **optional** and **only needs to be completed if your physical therapist determines that dry needling is appropriate for your condition and includes it in your treatment plan**. If dry needling is not recommended, you may leave this section blank.

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 Evidence In Motion has met requirements for Level 1 & 2 competency in Functional Dry Needling®, and is currently in training to become 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.

Are you pregnant? ☐ Yes ☐ No

Are you immunocompromised? ☐ Yes ☐ No

Are you taking blood thinners? ☐ Yes ☐ No

***DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.
You have the right to withdraw consent for this procedure at any time before it is
performed.***

Patient or Authorized Representative

Date

Relationship to patient (if other than patient)

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

Physical Therapist

Date