COLORADO PERFORMANCE PHYSICAL THERAPY

PATIENT INFORMATION

Patient Full Name: Preferred Name:

Address:

Date of Birth: Age: Sex: M/F

Cell Phone: Home Phone:

Email:

Body part/parts to be assessed at PT:

Date of injury/onset:

Have you received PT at other locations this year? Y/N How many sessions? _____
What for?

Imaging (x-ray, MRI, etc):

Employment/position:

Physician Information
MD or Referrer: Location:

How did you hear about Dr. Jesse? ☐Friend. Who? _____
☐Social Media ☐Website ☐Special Event

I authorize the release of any private health information necessary to process this claim.
I, the undersigned agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill for service. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.
I understand that upon discharge I may request, in writing, a copy of my records.

Signed Date

COLORADO PERFORMANCE PHYSICAL THERAPY

MEDICAL HISTORY

Name: _____ Age: _____

To ensure a thorough evaluation, please complete this health questionnaire.

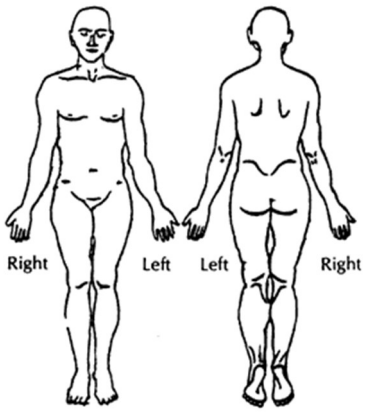
Check the box if you have or ever have had any of the following medial conditions.

☐Heart problems/Pacemaker	☐History of falls in which you were injured.
☐Lung problems	☐Arthritis
☐Diabetes	☐Osteoporosis ☐Osteopenia
☐Cancer	☐Difficulty breathing, swallowing.
☐High Blood Pressure	☐Shortness of breath, dizziness
☐Asthma	☐Fainting, seizures
☐Blood disorders, vascular disease	☐Unexplained weight change
☐Hepatitis/HIV	☐Pain at night that *won't change with position.*

Pain Stuff:
If you have pain, how bad is it from 0-10?
(0 is nothing, 10 is worst pain ever experienced)

- Currently as you sit here _____
- At lowest in the past week_____
- At worst in the past week _____

Draw where it hurts →



Recent surgeries or procedures and approximate date or year:

Medications you are taking:

Allergies:

Others healthcare providers you are seeing (MD, chiropractor, etc):

Signature_____ Date:_____

COLORADO PERFORMANCE PHYSICAL THERAPY

☐ I do not desire a copy of this consent form.

☐ I desire copy of this consent form.

FUNCTIONAL DRY NEEDLING® (FDN) 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 **Level 2 (54 hours of training)** competency in Functional Dry Needling® and is now 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.

I, (print name) _____, authorize Dr. Jesse Roles, PT, DPT, MTC, to perform FDN.

Please answer the following questions (Y/N):

Are you pregnant? ____ Are you immunocompromised? ____ Taking blood thinners? ____

DO NOT SIGN UNLESS YOU HAVE READ & UNDERSTAND THIS FORM

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

_____

Patient for Authorized Representative Date

_____ _____

Relationship to patient (if other than patient) Date (Patient name printed)

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_____

COLORADO PERFORMANCE PHYSICAL THERAPY

SUPPLEMENTAL MEDICAL QUESTIONNAIRE

for Functional Dry Needling® (FDN) and
Cupping/Myofascial Decompression (MFD) Consent

Please complete this additional medial history to ensure risk reduction with FDN.

	No	Yes (if yes, please explain)
Current infection	☐	☐
Compromised immune system	☐	☐
Lymph node removal/local lymphedema.	☐	☐
Respiratory illness	☐	☐
Autoimmune disease	☐	☐
Metal allergy	☐	☐
Surgery within past year	☐	☐ Body part/s and date/s:
Pacemaker	☐	☐
Arnold Chiari Malformation	☐	☐
Laminectomy (spinal bone removal)	☐	☐
Osteoporosis	☐	☐
History of pneumothorax	☐	☐
Abnormal bleeding or vascular disease	☐	☐
ANY disease which can be transmitted through bodily fluids	☐	☐

CUPPING/MYOFASCIAL DECOMRESSION (MFD) CONSENT

MFD involves placing suction over various parts of the body to decompress the layers of skin from the sub-cutaneous tissues, fascia, and muscle. The result is breaking of superficial adhesions in the connective tissue with improved range of motion and a decrease in pain. The most severe side effect is the presence of petechiae (bleeding in the dermis and sub-dermal tissues) which may last from 2 days to 2 weeks. MFD should not be performed if the patient has a significant bleeding risk or is on strong blood-thinners. Should petechiae appear, it is recommended to avoid ice immediately following treatment, and refraining from exposing the location to direct sunlight as these may increase the duration of the petechiae.

☐ I have read and understand the benefits and risks of MFD and consent to MFD.

Name: _____

Signature: _____ Date: _____