OHANA PHYSICAL THERAPY
DURANGO, COLORADO

PATIENT INTAKE INFORMATION

Date_____ DOB_____ Sex M F Pronouns_____

Name_____ Preferred Name_____

Phone_____ Apt Reminders(circle) Voice-Text-Email-None

Address_____

Email_____

Employer_____

Emergency Contact #_____ Relationship/Name_____

REFERRING

Referring Physician_____ Phone_____

Primary Care_____ Phone_____

What made you choose Ohana PT for your therapy?_____

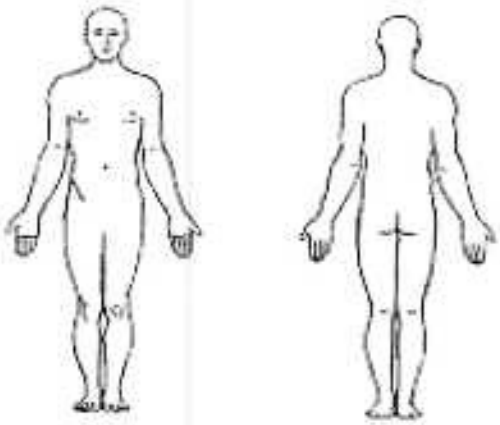
REASON FOR VISIT

What are we seeing you for? _____

Date when your symptoms began?_____ Surgery Date_____

Rate the severity of your pain on a scale from 0 to 10. 0= no pain, 5=moderate, 10=extreme

Currently_____ At its best_____ At its worst_____



Please Indicate Where You Are Experiencing Symptoms

Type of pain (circle)

Aching Dull Throbbing Sharp Shooting Burning Numbness Tingling

Are your symptoms constant or intermittent?(circle one) Constant Intermittent

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What activities are you having difficulty with?(circle one or more)

Sitting	Lying down	Sitting to standing	Reaching
Standing	Walking	Lifting	Coughing/Sneezing
Bending	Climbing stairs	Carrying	Other_____

HEALTH HISTORY

Have you received any of the following care for this condition (circle)

Medication Physical Therapy Chiropractic Massage

Have you had any of the following care for this condition? (circle and date)

X ray MRI CT Scan Bone Scan

MEDICAL HISTORY

Have you been diagnosed with any of the following?(circle)

Osteoporosis	Depression	High Cholesterol
Cancer	Hearing Impairment	Contagious Disease
Diabetes (I or II)	Seizures	Fibromyalgia
RheumatoidArthritis	Visual Impairment	Immunosuppression
Osteoarthritis	Thyroid Problem	TBI
High Blood Pressure	Kidney Disease	Parkinson's
Circulatory Problems	Stroke	Pregnancy
Anxiety	Vertigo	Pacemaker

Are you currently taking over the counter medications, vitamins, or supplements? Y N
Are you currently taking any prescribed medications? Y N
Please list, if yes_____

GOALS

Please provide 3 specific goals you would like to achieve from your therapy at Ohana PT
E.g. 1. Avoid surgery. 2.Reduce pain by 50% in 2 weeks. 3. Get back to playing golf

1._____
2._____
3._____

Please list any other injuries, surgeries and diagnosis that are not listed and associated dates.

_____
_____

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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 to resolve pain and muscle tension and will promote healing. This is not traditional Chinese Acupuncture, but 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 (Bria) or Level 2 (Carolyn and Andra) competency in Functional Dry Needling®. 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 a rare occurrence they might happen 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 my therapist to perform Functional Dry Needling in conjunction with my care at Ohana Physical Therapy.

Please answer the following questions:
Are you pregnant? Y N Are you immunocompromised? Y N Are you taking blood thinners? Y N

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 Signature Date Time

_____ _____
Relationship to patient (if other than patient) (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.

BR BJ CJ

_____ _____
Physical Therapist Date Time

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COVID-19 CONSENT TO TREAT

I understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

To proceed with receiving care, I confirm and understand the following:

- I understand my treatment at Ohana Physical Therapy may create circumstances, such as the discharge of respiratory droplets or person-to person contact, in which COVID-19 can be transmitted.

- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever	*Runny Nose
*Shortness of Breath	*Sore Throat
*Dry Cough	*Loss of Taste or Smell

- I am informed that Ohana Physical Therapy and their staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to Ohana Physical Therapy to proceed with providing care.

Patient or Authorized Representative Signature Date

Relationship to patient

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LATE CANCEL AND NO SHOW POLICY

I understand that my therapist has set aside time for my physical therapy treatment and by reserving this time, another patient who might also need physical therapy has been scheduled at a later time.

I understand that if I cancel my appointment within 24 hours of my scheduled appointment time it is unlikely that my therapist will be able to fill the appointment time on short notice.

As such, **I agree to pay the $50 late cancellation/no show fee if I cancel my appointment within 24 hours of my scheduled appointment time. NOTE: Monday appointments must be canceled by the preceding Friday at 4PM as messages left over the weekend are not received until Monday morning. I also agree to pay the $50 cancellation/no show fee if I do not come to my appointment without giving notice. Any cancellation before 24 hours will be free of charge.**

I understand that Ohana Physical Therapy will waive the $50 cancel fee for situations that they deem appropriate such as inclement weather, illness, or emergencies.

_____

Patient or Authorized Representative Date

_____

Relationship to Patient