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?_____

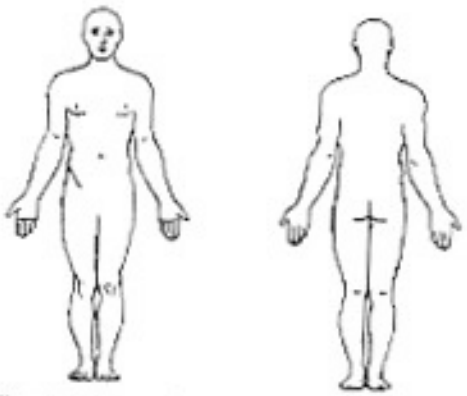
REASON FOR VISIT

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 Andre) 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 DJ CJ
_____ _____
Physical Therapist Date Time

Ohana Physical Therapy Cancellation Policy & Agreement

At Ohana Physical Therapy, our mission is to provide exceptional care and consistent scheduling for all of our patients. Each appointment time is reserved specifically for you, allowing us to give you our full attention and deliver the best possible care.When an appointment is missed or canceled on short notice, it does more than disrupt your own progress; it prevents another patient who needs care from being seen, leaves your physical therapist's time unused, and directly impacts the sustainability of our small business.

Our updated policy reflects the realities of running a patient-centered practice and the standard expectations across the broader **health and wellness industry**, where reserved appointment times are respected and held accountable to ensure fairness and continuity of care.

Updated Cancellation Policy Effective Monday, 11/10/25

- A **$75 fee** will be charged for any **missed appointment** or **cancellation made with less than 24 hours' notice**.
- The 24-hour window is calculated **to the minute** — cancellations made fewer than 24 hours before your scheduled appointment time will be subject to the fee.
- This policy applies to **all appointment types**, including initial evaluations, follow-up visits, re-evaluations, and self-pay sessions.
- Because of the impact missed appointments have on patient care and clinic operations, **no exceptions will be made** — including for illness, transportation, or childcare challenges.

Payment of Fees
The $75 fee will be collected at the time of cancellation when possible. If payment is not made at that time, an invoice will be sent, and payment will be due upon receipt.

How to Avoid the Fee
If you need to cancel or reschedule, please contact us at least 24 hours before your appointment time by calling 970-247-7895. We'll be happy to find another time that works for you.

Acknowledgment
By signing below, I acknowledge that I have read, understand, and agree to the Ohana Physical Therapy cancellation policy. I understand that a $75 fee will be charged for missed or late-canceled appointments, that this applies to all appointment types, and that no exceptions will be made.

Patient Name: _____ **Date:** _____

Patient Signature: _____