Medical History Questionnaire

Name: _____

Are you currently receiving home health or chiropractic services? No Yes _____
(Home Health Agency)

Have you had any imaging performed? No Yes If yes, what type? X-Ray MRI CT Scan Doppler Ultrasound

Do you have any allergies? Yes No If yes, please list _____

PLEASE CIRCLE HEALTH PROBLEMS PAST OR PRESENT

COVID-19	Coughing	Fever	
Cardiac	Muscular	OB/GYN	Weight _____
Circulatory	Endocrine	Psychological	
High Blood Pressure	Digestive	Drug Dependency	Height _____
Diabetes	Bladder	Alcohol	
Respiratory	Bowel	Smoking	
Cancer	Headaches	Sleep Disorder	
Neurological	Dental	Swallowing Disorder	
Arthritis	Visual	Other	
Fractures	Communicable/Infectious Diseases		

Have you had any falls this year? Yes No If yes, please describe _____

Do you have a pacemaker? Yes No Metal Implants? Yes No

Are you or could you be pregnant at this time? Yes No

Surgeries: list type and date _____

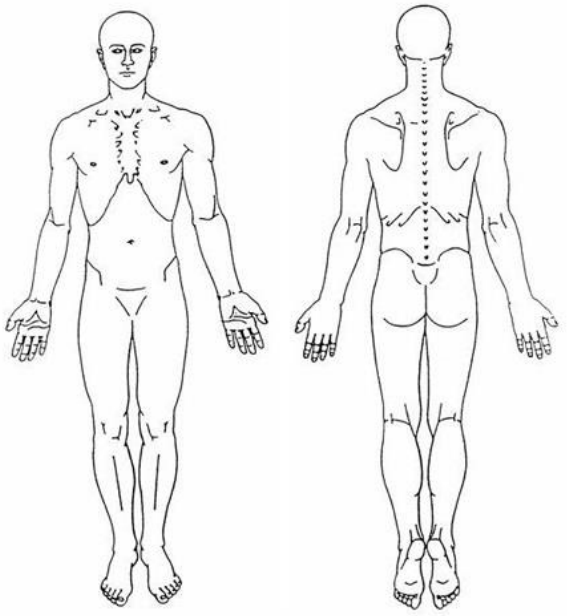
_____

Have you ever received Physical, Occupational or Speech Therapy? Yes No

If so, for what type of problem? _____

What are your goals for treatment? _____

Are there any other considerations that your therapist should know? _____



Please mark the area of pain

Area and Behavior of Pain:

Initial site of pain _____

Where is the pain now? _____
(See diagram at left)

Rate your pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Possible

PATIENT SIGNATURE _____

DATE _____

Newport Osteopractic Physical Therapy

261 Howard Blvd, Newport NC, 28570

INFORMED CONSENT FOR PHYSICAL THERAPY TREATMENT

• PHYSICAL THERAPY: Physical therapy is the health care profession that remediates impairments, functional limitations and activity participation restrictions and promotes optimal movement, function, and quality of life through accurate examination, diagnosis, and physical intervention. It is carried out by licensed physical therapists.

• SPECIALIZED CARE: Newport Osteopractic Physical Therapy employs specialized physical therapists who have earned an advanced level of training and competence in orthopedic practice and manual therapy practice. This allows Newport Osteopractic Physical Therapy to offer advanced level of care to its patients.

• INFORMED CONSENT: The term informed consent means that potential risks, benefits, and alternative treatments have been clearly explained. Our physical therapists offer a wide range of specialized treatment and services and will provide individualized information at the initial visit concerning treatment and options available for your specific condition.

• PATIENT RIGHTS: It is you right to ask your physical therapist about the treatment they have planned for you, given your individual history, physical therapy diagnosis, symptoms, and examination findings. Consequently, it is your right to discuss the potential risks and benefits for your physical therapy treatment. It is your right to decline any part of your treatment at any time during the session if you feel discomfort, pain, or have other unresolved concerns.

• POTENTIAL BENEFIT: Newport Osteopractic Physical Therapy is dedicated to maximizing the benefits you receive from treatment. These may include an improvement or resolution of your symptoms and an increase in your ability to perform daily activities with optimal movement. It is our goal that you experience increased strength, awareness, flexibility, and endurance with movement and that you experienced decreased pain and discomfort. You should also gain a greater knowledge about independently managing your condition and return to a level of optimal function.

• POTENTIAL RISK: There is no guarantee of a positive outcome for your condition. Risks of manual physical therapy and exercise-based treatment include aggravation of existing symptoms, discomfort, pain, and swelling; these symptoms are usually temporary. If you experience serious symptoms such as fainting, dizziness, light-headedness, shortness of breath, or unexplained muscle weakness that was not discussed as a possible outcome of your treatment, contact your physical therapist and/or physician immediately.

• MANUAL THERAPY:

o Joint mobilization is a skilled, passive movement of joint surfaces to reduce pain or improve mobility

o Joint manipulation is a mobilization technique utilizing a high acceleration, low amplitude thrust.

o There is risk associated with spinal manipulation. Adverse effects of cervical spine manipulation may include temporary increase in neck pain, radiating arm pain, headache, dizziness, impaired vision or ringing in the ears; rarely, serious complication can occur, the most serious being disruption of blood flow to the brain leading to stroke or death. The risk of severe neurovascular compromise has been reported between 1/50,000 to 1 in 5 million manipulations. The most serious adverse effect of lumbar spine manipulation is cauda equina syndrome, which causes extreme pressure on

the nerves at the bottom of the spinal cord; symptoms associated with cauda equine include urinary retention, fecal incontinence, and widespread neurological symptoms in the legs. The risk of serious complication in lumbar spine manipulation is extremely rare, reported at less than 1 in 100 million manipulations.

I voluntarily consent to the performance of physical therapy examination and treatment on myself (or on the patient named below, for whom I am legally responsible). I understand the potential risks and benefits of physical therapy interventions and have been provided with adequate information to make an educated decision regarding my care. My physical therapy provider has discussed the goals and purpose behind the proposed treatment and has educated me about alternative types of treatments for my condition. I also understand that the results from the physical therapy treatment are not guaranteed for my condition. I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to the recommended physical therapy treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment. All of the questions concerning this care and treatment have been answered to my satisfaction.

Printed Name _____

Signature _____

Date_____

DRY NEEDLING CONSENT AND INFORMATION FORM

What is dry needling?

Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low back pain.

Is Dry Needling safe?

Drowsiness, tiredness or dizziness occurs after treatment and a small number of patients (1 to 3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15 to 20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60 to 70% of treatment. Existing symptoms can get worse after treatment less than 3% of patients; however, this is not necessarily a bad sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less than one per 10,000 (less than 0.01%) of treatment. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling induced pneumothorax commonly do not occur until after treatment is over, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can cause pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

Is there anything your practitioner needs to know?

1) Have you ever fainted or experienced a seizure? YES/NO
2) Do you have a pacemaker or any other electrical implant? YES/NO
3) Are you currently taking anticoagulents (blood-thinners e.g. aspirin, Warfarin, Coumadin) YES/NO
4) Are you currently taking antibiotics for an infection? YES/NO
5) Do you have a damaged heart valve, metal prosthesis or other risk of infection? YES/NO
6) Are you pregnant or actively trying for a pregnancy? YES/NO
7) Do you suffer from metal allergies? YES/NO
8) Are you a diabetic or do you suffer from impaired wound healing? YES/NO
9) Do you have hepatitis B, Hepatitis C, HIV, or any other infectious disease? YES/NO
10) Have you eaten in the last 2 hours. YES/NO
11) Single –use, disposable needles are used in this clinic.

STATEMENT OF CONSENT

I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

Signature:_____

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

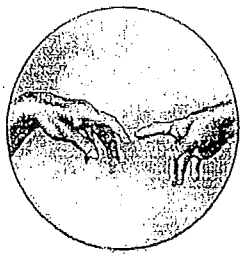
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.



Newport Osteopractic Physical Therapy Appointment Policy

The main therapy treatment goal of Newport Osteopractic Physical Therapy is to improve each patient's ability to function. In consideration of this goal, please make an effort to attend all appointments. If you are unable to attend, please call (252) 777-4051 at least 24 hours before your scheduled appointment. If you do not contact us prior to 24 hours you will be charged a non negotiable $25.00 cancelation fee. If it's a no call no show a non negotiable fee of $50.00. Effective Immediately.

If you are more than 10 minutes late for an appointment, we may need to reschedule your appointment. If you miss more than 2 appointments without 24 hour notification, we will remove your future appointments from the schedule. We will also revisit your treatment plan with your physician.

DATE:_____

SIGNATURE:_____

261 Howard Blvd
Newport NC 28570

Authorization to Release Health Information

_____ _____

Patient Name Date of Birth

_____ _____

Telephone Social Security

Records to: Newport Osteopractic PT Records from:
Phone (252) 777-4051 Fax (252) 777-4053

This information is being disclosed for the purpose of Continuing Healthcare covering from_____to_____.

Complete Health Record to be disclosed or (check appropriate line)

History and Physical_____ Progress Notes_____ ray/Ultrasound/MRI_____Consults_____

I understand that specific information to be released may include AIDS and HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that if I request copies of records for myself or a member of family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire ninety days from the date of signature. The physician and employees are released from any legal responsibility or liability or disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at anytime, except to the extent that action has been taken in reliance on this authorization for the purpose stated above.

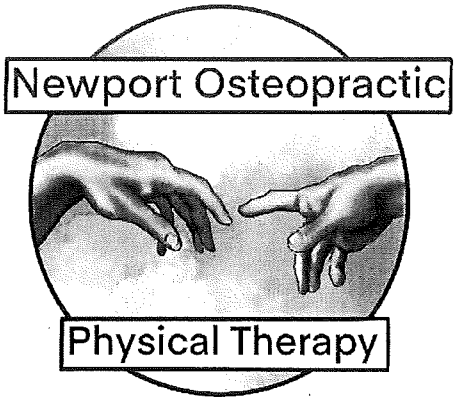
I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____

Signature of Patient or Legal Guardian Relationship to patient Date

_____ _____

Signature of Witness Date



261 HOWARD BLVD
NEWPORT NC 28570
PHONE 252-777-4051
FAX 252-777-4053

HIPPA COMPLIANT MEDICAL AUTHORIZATION

FOR DISCLOSURE OF HEALTH INFORMATION

To whom it may concern:

I,_____, _____

Name Date of Birth

hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insure, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA) TO

_____, _____

Name Date of Birth, Phone Number, Relationship to Patient

_____, _____

Name Date of Birth, Phone Number, Relationship to patient

Regarding my complete medical history and physical and mental condition both prior to and subsequent to the date of this authorization, regardless of loss time. The person(s) named above is/are hereby designated as my "personal representative(s)" as that term is used within HIPPA.

I intend the person(S) listed above to have the authority to gain immediate access to my medical records.

Upon presentation of this authorization (or a photo copy) you are authorized to release a copy of these records to any person who is my personal representative. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPPA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPPA (45 CFR Section164). This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under Illinois law.

Signature of person authorizing discloser:

_____ _____

Signature of person authorizing disclosure Date

_____ _____

Signature of witness Print name of Witness