# 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 ______________________________________________________________________________

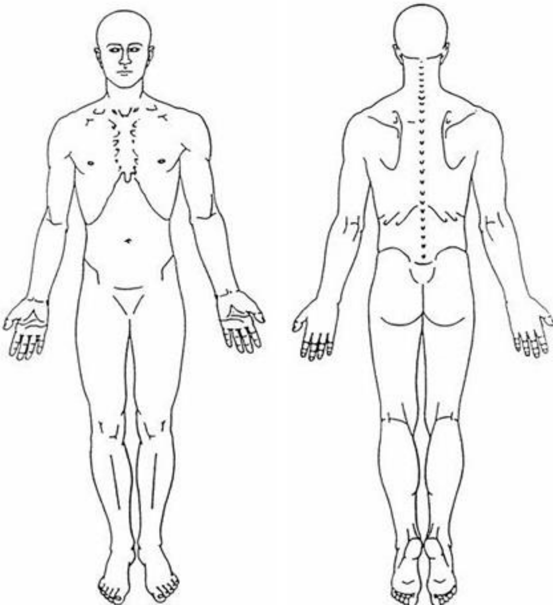
___________________________________________________________________________________________________________

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:_______________________________________________

# NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

## SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

## SECTION 2 - PERSONAL CARE

- ❑ 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 do not get dressed. I wash with difficulty and stay in bed.

## SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

## SECTION 4 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

## SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

## SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

## SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

## SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

## SECTION 9 – READING

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

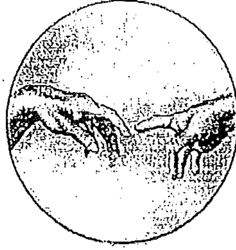
## SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME ______________________________________________ DATE ________________

SCORE ____________ [50] BENCHMARK -5 = ____________

Copyright: Vernon H. and Hagino C., 1987. Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics 1991; 14:409-415. Copied with permission of the authors.



# 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.

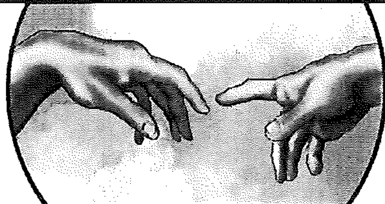
I understand that there may be a fee for preparing and furnishing this information.

________________________________ ______________________ ________________

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