Welcome!

Transformative Pain Care and Physical Therapy, PLLC

Thank you for choosing Transformative Pain Care and Physical Therapy for your physical therapy and wellness needs! We appreciate the opportunity to work with you to meet (and hopefully exceed!) your goals. In order to provide the best possible care, we need to collect some information from you and get your consent to proceed with treatment. Please take some time to fill out the following forms before your first visit:

- Patient intake form, so we know how to reach you!
- Medical history form (we know it's detailed, but we need to cover all the bases to make sure nothing important is missed, especially if you are coming in without a physician's referral).
- Informed consent form. This way, you know what to expect from us, and we know that you know the policies and procedures we follow related to treatment, privacy, information transfer and payment.
- Dry needling consent form. If you would like dry needling as a treatment modality, this form is required.

Please print and complete these forms. If you have the ability, scan them and send them back to me via email to paindrkevin@gmail.com or simply bring them with you on the first day so we can get started right away. If you are unable to do this, I will have forms with me for you to complete, but this may take a considerable amount of time away from our first visit.

Thank You SO MUCH!

Kevin R. Johnson, PT, DPT, TPS

Kevin R. Johnson, PT, DPT, TPS
Owner, Transformative Pain Care and Physical Therapy, PLLC

PATIENT INFORMATION		
First Name:	Last Name:	Date of Birth:
Street Address:	City/State:	Zip Code:
Preferred Phone Number:	Secondary Phone Number:	Email Address:
Employer:	Work Phone:	Can you be contacted at work re: appointment? Yes No
EMERGENCY CONTACT Name:	Phone Number(s):	Relationship
Second Contact:	Phone Number(s):	Relationship
Other relevant information you'd like us to know:		

Patient Consent Form

Transformative Pain Care and Physical Therapy, PLLC

Consent to Treat

I consent for the physical therapists associated with Transformative Pain Care and Physical Therapy, PLLC, to provide direct evaluation and treatment to me as advised by my treating clinician. I acknowledge and consent that any claims that may arise from my treatment are only valid against the individual provider whom I am seeing on the treatment day in which the claim occurs. I hold harmless the independent providers unrelated to my care or claim.

____ (initial)

Attendance

I understand that a 24-hour notice is requested for cancellations. Providers at Transformative Pain Care and Physical Therapy reserve the right to refuse to treat patients who habitually cancel or fail to show up for scheduled appointments.

_____ (initial)

Privacy

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician communications

I have been informed by you of your NOTICE of PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of practices prior to signing this consent form. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Act.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this content in writing at any time, except to the extent that you have taken action relying on this content.

_____ (initial)

_____ Signature/Date

Electronic Information

I understand that all therapists associated with Transformative Pain Care and Physical Therapy, PLLC, use a secure, HIPPA compliant, online documentation system called WebPT, as well as e-mail, fax, and cell phones (voicemail and texting) in their daily operations. I understand that technology puts some of my personal information at risk (for example, a cell phone with my contact information can be misplaced or stolen). Although therapists use password-protected devices, information regarding my treatment may be transmitted electronically, carrying with it the inherent risk of being viewed by an unintended audience. Any payment or credit card information will ONLY be transmitted on a confidential, secure banking platform (Square).

_____ (initial)

Direct Pay Policy

Transformative Pain Care and Physical Therapy is a direct-pay physical therapy practice. Shifting the responsibility of payment onto the patients directly eliminates the need for office staff to verify insurance coverage, bill third-party payers, and track down delayed payments. Payment for all services is due at the time of service. Payment can be made via cash, check, Venmo, ATM/Debit card or credit card. We do NOT bill insurance for physical therapy services rendered. Some private insurance companies may cover part or all of the services provided, with Transformative Pain Care and Physical Therapy providers considered "out-of-network" providers. It is the responsibility of the patient to obtain this information from their insurance company and submit appropriate paperwork to their insurance carrier. We can provide a detailed invoice for services rendered. These invoices may include diagnosis information as well as a brief description of services rendered:

- PT Evaluation
- Manual Therapy
- Neuromuscular Re-Education
- Therapeutic Exercise
- Therapeutic/Functional Dry Needling
- Wellness/Prevention

Note that most traditional health insurance companies ONLY cover services aimed at restoring patients to a reasonable level of function following an injury or disease. Services such as therapeutic massage, wellness/prevention, performance enhancement and maintenance therapy do not typically fit these criteria. Health Savings Accounts and Flexible Savings Accounts may be more amenable to covering such services.

"I have read and understand the Patient Agreement for Cash-Based Policy and agree to pay for services rendered, in full, at the time of service. I understand that it is my responsibility to work with my health insurance, HSA or FSA to try to obtain any reimbursement that I may be eligible for."

_____ (initial)

I AGREE TO ALL OF THE ABOVE NOTED POLICIES OF TRANSFORMATIVE PAIN CARE AND PHYSICAL THERAPY

_____ _____

Patient Signature Date

_____ _____

Parent Signature (if patient is a minor) Date

TRANSFORMATIVE PAIN CARE AND PHYSICAL THERAPY, PLLC – MEDICAL HISTORY FORM

Name: _____ DOB: _____ Age: _____

Primary Complaint: _____ Date of onset: _____

Referred by: _____ Primary Physician: _____

Other clinicians you are currently seeing: _____

Date of next MD appointment: _____

Date of last MD appointment: _____

Body Chart

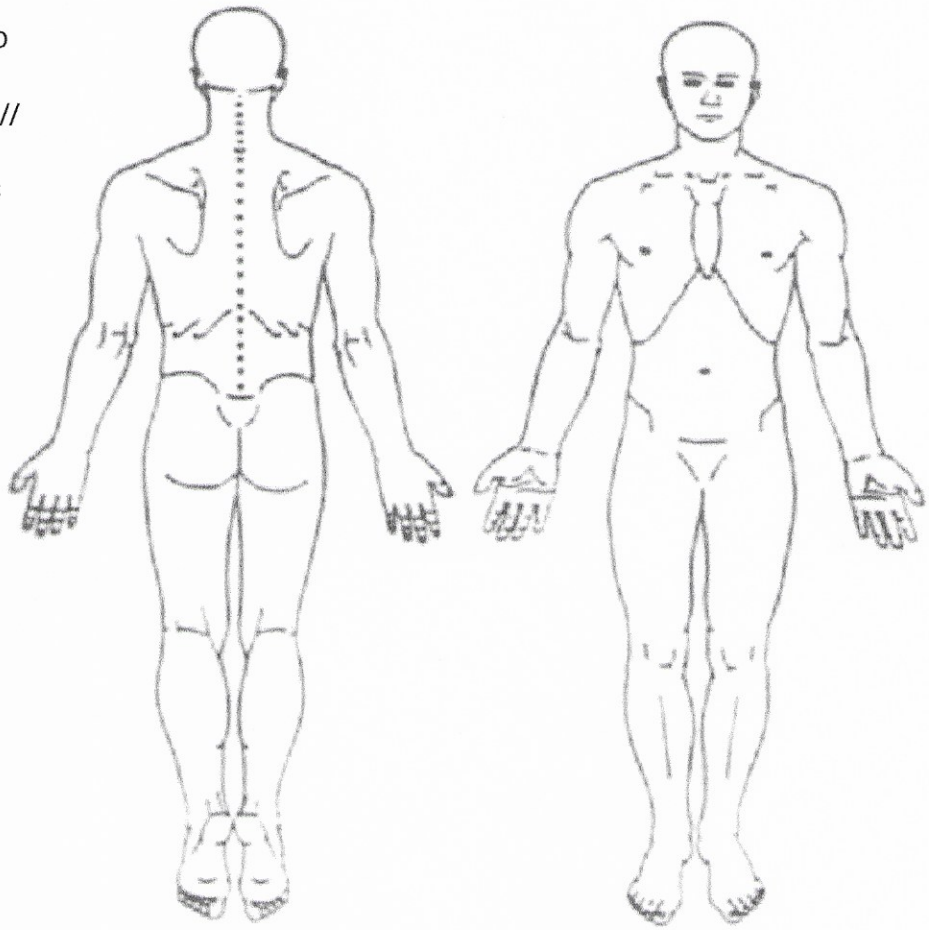
Please indicate the area(s) of concern:

Pain: XXXX

Numbness: OOOO

Tingling: //////////

Other Sensations:



Personal Medical History

Do you have, or have you ever had:

Heart Disease	Yes	No	Arthritis	Yes	No
Blood Clots	Yes	No	Osteoporosis	Yes	No
Angina / Chest Pain	Yes	No	Joint Replacement	Yes	No
High Blood Pressure	Yes	No	Fracture	Yes	No
Heart Attack	Yes	No	Diabetes	Yes	No
Bleeding Disorders	Yes	No	Hypoglycemia	Yes	No
Anemia	Yes	No	GERD / Acid Reflux	Yes	No
Peripheral Vascular Disease	Yes	No	Ulcers / Stomach Problems	Yes	No
Aneurism	Yes	No	Hepatitis / Jaundice	Yes	No
Stroke	Yes	No	Chronic Bronchitis	Yes	No
Epilepsy / Seizures	Yes	No	Emphysema	Yes	No
Multiple Sclerosis	Yes	No	Shortness of Breath	Yes	No
Parkinson Disease	Yes	No	Pneumonia	Yes	No
Guillain-Barre Syndrome	Yes	No	Asthma	Yes	No
Polio / Post-Polio	Yes	No	Tuberculosis	Yes	No
Headaches	Yes	No	Urinary Tract Infection	Yes	No
Depression / Anxiety / Bipolar	Yes	No	Kidney Disease / Dialysis	Yes	No
Eating Disorder	Yes	No	Sexually Transmitted Disease	Yes	No
Chemical Dependency	Yes	No	HIV / AIDS	Yes	No
Fibromyalgia/Myofascial Pain Syndrome	Yes	No	Urinary or Fecal Incontinence	Yes	No
Thyroid Problems	Yes	No	Prostate Problems	Yes	No
Gout	Yes	No	Skin Disorders	Yes	No
Rheumatic Fever/Scarlet Fever	Yes	No	Non-healing Wounds	Yes	No
CANCER	Yes	No	ALLERGIES	Yes	No
Type: _____			List: _____		

Family Medical History

Have any of your immediate family members (parents, siblings, and children) been told they have:

□ Cancer □ Heart Disease □ Diabetes □ Stroke □ Arthritis □ Anxiety/depression

□ Other (please describe): _____

_____

Surgeries: Please list surgeries you have had along w/ approximate dates:

_____

_____

GENERAL HEALTH

How would you rate your health?	□ Excellent	□ Good	□ Fair	□ Poor
Do you exercise regularly? If yes, type:_____			□ Yes	□ No
Any illnesses in the past 3 months? (cold, flu, bladder/kidney infection, etc.)			□ Yes	□ No
Females: Is there any possibility you are pregnant?			□ Yes	□ No
Any implants of any kind in your body (ex: joint, breast, pacemaker, transplant)			□ Yes	□ No
Have you fallen in the past year?			□ Yes	□ No
If yes, have you been injured because of the fall?			□ Yes	□ No
Have you been feeling down, depressed or hopeless?			□ Yes	□ No
Have you lost interest or pleasure in doing things?			□ Yes	□ No
Have you had any diagnostic tests (MRI, X-ray, lab) recently? If yes, please list:			□ Yes	□ No

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Symptoms

Do you have, or have you recently had, any of the following?

□ Blood in urine, stool, vomit, or sputum	□ Cough	□ Difficulty swallowing/speaking
□ Dizziness, fainting, blackouts	□ Dribbling of urine	□ Memory loss
□ Fever, chills, sweats (day or night)	□ Inability to tolerate exertion	□ Confusion
□ Nausea, vomiting, loss of appetite	□ Numbness / tingling	□ Sudden weakness
□ Bowel/bladder (diarrhea/constipation)	□ Swelling or lumps anywhere	□ Trouble sleeping
□ Throbbing sensation	□ Problems seeing or hearing	□ Skin rash or other changes
□ Unexplained weight loss or weight gain	□ Unusual fatigue, drowsiness	□ Heart Palpitations / fluttering
□ Heat or cold intolerance	□ Joint pains or muscle cramps	□ None of these

Medications

Please list any current prescription or over-the-counter medications, supplements, or herbal products:

Are you on Coumadin (Warfarin)? □ Yes □ No

SOCIAL HISTORY

Tobacco Use: □ Yes □ No □ Previously, but I quit When did you quit?_____

If yes, # of years you've smoked/chewed ____ Amount you smoke/chew per day _____

Alcohol Use: □ Yes □ No □ Previously, but I quit When did you quit?_____

If yes, how often and how much do you drink? _____

Illicit Drug Use: □ Yes □ No □ Previously, but I quit Please specify: _____

Caffeine Intake: _____ # drinks/servings per day Nutrition Concerns? _____

Artificial sweeteners (NutraSweet, Aspartame, Splenda, etc.): □ Yes □ No __ # drinks/servings per day

Occupation: _____ Company worked for: _____

Living Situation: □ Alone □ With someone □ Home/apartment □ Other: _____

Marital Status: □ Married □ Single □ Widowed □ Divorced □ Other

OTHER

Do you have any religious or cultural concerns that may affect your treatment? □ Yes □ No

If yes, please specify: _____

Do you have any barriers to learning that your therapist should be aware of? □ Yes □ No

If yes, please specify: _____

Do you have any other symptoms, anywhere else in your body, not covered above? □ Yes □ No

Please share anything else about your health history that you would like to share not covered above:

_____

_____

_____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

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 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 Evidence In Motion has met requirements for **Level 1** ***(27 hours of training)*** competency in Functional Dry Needling®, and is currently in training to become 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.

Procedure I, _____, authorize **Kevin R. Johnson, PT, DPT, TPS** to perform Functional Dry Needling® for my diagnosis of _____.

Please answer the following questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No **Are you taking blood thinners?** Yes No

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 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.

_____ _____ _____
Physical Therapist Date Time

☐ Patient was offered copy of consent and refused

☐ Patient was given copy of consent