GEORGIA
Physical Therapy & Sports Medicine Center

Past Medical History Questionnaire

Patient Name	**Date of Birth**
Reason for Therapy	**Date of Injury or Onset**
Have you ever received therapy for the condition mentioned above? □ **Yes** □ **No** **Treatment Received:**	**If so when?** / **Previous Treatment Successful** □ **Unsuccessful** □
Have you ever received home health therapy for this condition? □ **Yes** □ **No** **Name of home health therapist/provider:** **Therapist/provider contact info:**	**If so, when & how long?** / **Previous Treatment Successful** □ **Unsuccessful** □
Could you be or are you pregnant? □ **Yes** □ **No**	

Do you now or have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis	□	□	Diabetes	□	□	Thyroid Problems	□	□
Osteoporosis	□	□	Anemia	□	□	Headaches	□	□
High Blood Pressure	□	□	Hypersensitivity to Heat/Cold	□	□	Head Injury / Concussion	□	□
Heart Disease	□	□	Swelling in Ankles	□	□	Hernia	□	□
Heart Attack	□	□	Deep Vein Thrombosis (DVT)	□	□	Kidney / Bladder Problems	□	□
Pacemaker	□	□	Seizures / Epilepsy	□	□	Previous Fractures	□	□
Vascular Disease	□	□	Metal in Body or Surgical Implants	□	□	Previous Surgeries	□	□
Stroke	□	□	Cancer / Tumor	□	□	Hearing Loss	□	□
Asthma	□	□	Recent Weight Loss or Gain	□	□	Depression	□	□
Shortness of Breath	□	□	Current Infection(s)	□	□	Anxiety	□	□
Chronic Cough	□	□	Tuberculosis	□	□	Substance Abuse	□	□
Fainting Spells	□	□	Hepatitis	□	□	Other	□	□

If you answered 'Yes' on any of the above, please explain and give approximate date(s):	
Do you have any allergies? □ No □ Yes, list allergies	
Are you presently taking any medications? □ No □ Yes, list medications and specify condition	
The information is correct to the best of my knowledge	
x	
Patient/Parent/Guardian Signature	Date

GEORGIA
Physical Therapy & Sports Medicine Center

Patient Registration

Patient Information: Please complete all areas			
		Who told you about us?	
Last Name:	Suffix:	First Name:	Date of Birth
Address:		Email Address	
City:		State:	Zip:
Home//Cell Phone		Work/Cell Phone:	
Sex: □ Male □ Female		Marital Status: □ Married □ Single □ Other _____	

Insured Party/Responsible Party: (leave blank if same as patient)			
~~Social Security~~ Accident Patients Only ~~Number:~~		Date of Birth:	Relationship To Patient:
Last Name:	Suffix:	First Name:	MI:
Address:		Email Address	
City:		State:	Zip:
Home Phone		Work Phone:	
Sex: □ Male □ Female		Marital Status: □ Married □ Single □ Other _____	

Patient's Employer Information			**Insured's Employer Information (leave blank if same as patient)**		
Employer Name:			Employer Name:		
Employer Address:			Employer Address:		
City:	State:	Zip:	City:	State:	Zip:

Emergency Contact Information		
Last Name:	First Name:	MI:
Relationship: □ Spouse □ Parent □ Friend □ Other _____		
Home Phone:	Work Phone:	

Other Information	
Date of Injury (Onset):	Accident: □ No Accident □ Auto □ Work □ Other _____
Description of Injury:	If Auto Accident, list State where accident occurred.

Patient Certification and Signature	
I certify that all of the information provided herein is true and correct.	
Patient/Guardian Signature:	Date:

Facility Use Only	
Facility #:	Account#:
Date of Eval:	Therapist:

Patient Authorization

Patient Name:	
Release of Information	
All information provided herein is true and correct. I hereby consent to treatment. I give permission to Georgia Physical Therapy and Sports Medicine Center and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. I authorize Georgia Physical Therapy and Sports Medicine Center and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. Information without patient identifiers may be used for quality assurance purposes. I have read and understand the above release.	
Patient or Guardian Signature:	Date**:**

Assignment of Benefits**:**	
I authorize payment directly to Georgia Physical Therapy and Sports Medicine Center, its subsidiaries and/or affiliates for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.	
Patient or Guardian Signature:	Date:

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)	
I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Georgia Physical Therapy and Sports Medicine Center. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.	
Patient or Guardian Signature:	Date:

Payment Guarantee	
I agree to pay Georgia Physical Therapy and Sports Medicine Center, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Georgia Physical Therapy and Sports Medicine Center and/or its affiliates or subsidiaries.	
Patient or Guardian Signature:	Date:

GEORGIA
Physical Therapy & Sports Medicine Center

Cancellation/No Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our clinicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the clinician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $50 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

I understand the "no-show" policy of Georgia Physical Therapy and agree I may be charged $50 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

Patient Name (please print) _____

Patient Signature _____

Date _____

DRY NEEDLING CONSENT & INFORMATION FORM

What is Dry Needling?

Dry needling is a form of therapy in which fine needles are inserted into the myofascial trigger points (painful knots in the 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 doesn't 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 in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. 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 1 per 10,000 (less than 0.01%) treatments. 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 the treatment session, 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, a 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. Nerved or blood vessels may be damaged from dry needling which can result in 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 e vent (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 anticoagulants (blood thinners e.g aspirin, warfarin, coumadin)? YES/N0
4. Are you currently takin 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 two hours? YES / NO

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 have dry needling treatments. I understand that I can refuse treatment at any time.

Signature: _____ Date: _____

GEORGIA
Physical Therapy & Sports Medicine Center

HydroWorx Pool Precaution

The therapy pool in our facility is disinfected with BROMINE. Like any chemical, some people may experience skin irritation to this substance. To minimize risk of irritation, all patients using the pool are instructed to shower with soap both **before and after** pool therapy. In addition, moisturizer of your choice would be indicated to prevent drying of the skin.

General Pool Guidelines

1. Shower before pool use with soap.
2. Please avoid lotions, oil, or perfumes if you know you will be entering the pool. (Pre-pool shower MUST remove these products before entering the pool.)
3. Clothing worn in the pool must be clean.
4. Towels provided by GA Physical Therapy & Sports Medicine Ctr are laundered after every use. Patients are invited to use facility towels or provide personal towels from home.
5. Immediately following pool use, shower thoroughly with soap before leaving the facility.
6. Be aware of pool water tracked out of the pool area onto other floors in the clinic. Our floors are non-skid materials, but water may be slippery.

Precautions/Contraindications of Aquatic Physical Therapy

Please check if any of these apply to you currently:

____Incontinence of feces or urine
____Contagious skin rashes
____Abnormal blood pressure
____Perforated eardrum or ear infection
____Open wounds unable to be covered by bio-occlusive dressing
____Fever
____Epilepsy/seizures
____Infectious diseases such as AIDS, Hepatitis, MRSA
____Hydrophobia – fear of water
____Kidney diseases
____Medications that may cause drowsiness
____DVT, pulmonary embolism
____Heart condition Patient

I voluntarily agree to participate in Aquatic Physical Therapy at Georgia Physical Therapy & Sports Medicine Center and I will abide by the pool rules and recommendations of the Physical Therapist. I understand that there are risks associated with aquatic therapy including, but not limited to, hypotension (decrease in blood pressure), skin reactions to water, dizziness, falls and drowning. Should any complications occur, I agree to the medical care required to correct the complication. I fully understand the risks and responsibilities of participating in the aquatic therapy program. I absolve GA Physical Therapy of any liability for falls due to wet floors.

Signature:_____Date:_____