MEDICAL HISTORY/SUBJECTIVE INFORMATION

Patient Name: _____ **DOB**: _____

Patient Address: _____**City:** _____ **State:** _____ **Zip**:_____

Primary Number: _____ **SSN**: _____ **Email address**: _____

Sex: ☐ **Male** ☐ **Female** **Height:** _____ **Weight:** _____ **T-Shirt Size** _____

Are you currently in physical therapy somewhere else? YES_____ **NO**_____

How did you hear about us? ☐ **Friend**_____ ☐ **Physician**_____ ☐ **Facebook** ☐ **Other**_____

Do you use tobacco products of any kind? Please specify product, frequency & duration:

_____

In your own words, describe the current problems as you see them? (If MVA, where were you hit? Did you go to the ER? Have you seen a Dr?)

_____

_____

How long has this been affecting you (include Date)? _____

Have you received any treatment for this injury? If YES, please specify what procedure, including results, and/or treatment you received, name of the facility and the date performed. (ie: X-ray, MRI, CT scan, Injections, Past Physical Therapy Treatment etc):

_____

_____

What treatment was most beneficial? _____

Have you had or been scheduled for surgery? ☐ **Yes** ☐ **No** **If yes, indicate date of surgery**_____/____/_____

What is your current occupation? _____**What are the physical requirements?** _____

Please provide any additional information concerning your past medical history and/or conditions. Including all surgical procedures:_____

_____

Please list ALL medications and dosage:

_____

_____

Have you ever been diagnosed with or experienced ANY of the following conditions? (Check ALL that apply)

☐ **Tuberculosis**	☐ **Cancer**	☐ **Bowel/bladder problems**	☐ **Respiratory Problems**	☐**Pacemaker**	☐ **Epilepsy**
☐ **Diabetes: (circle) Type 1 or 2**	☐ **Stroke/ CVA**	☐ **Emotional/psychiatric problems**	☐ **Heart Condition** ☐**HIV/Aids**	☐ **Hepatitis**	☐**Headaches**

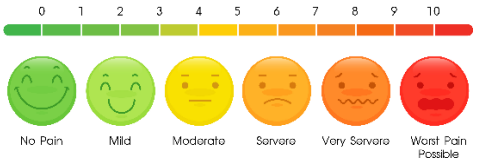
Are your symptoms ☐ Constant ☐ Intermittent ☐ Getting better ☐ Getting Worse

Describe your pain ☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Radiates ☐ Sharp ☐ Stabbing

What makes your symptoms better? _____

What makes them worse? _____

Please rate your pain using the scale:



Best: _____

Current: _____

Worst: _____

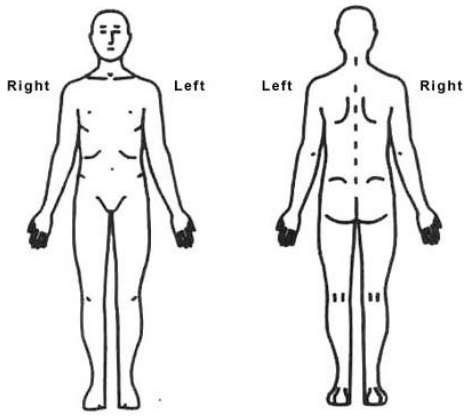
☐**Exercise: What Type**? _____

Any Problems with them? ☐ **No** ☐ **Yes**_____

Do you live alone? ☐ **Yes** ☐ **No. Do you use assistive equipment**? ☐ **Yes** ☐ **No**

If yes, please specify type of equipment: _____

mark the diagram reflecting location of symptoms.



Office use: HR_____/_____ BP: _____/_____

Other than your primary issue, what other symptoms have you experienced? (Check all that apply)

- ☐ **Numbness or Nerve Pain**
- ☐ **Slow Healing**
- ☐ **High Blood Pressure or Blood flow issues**
- ☐ **Sinus Inflammation or irritation**
- ☐ **Muscle or Tendon Healing Problems**
- ☐ **Inflammation**
- ☐ **Uncontrolled Stress or Anxiety**
- ☐ **Decreased Immune Function**
- ☐ **Diet Resistant Weight Gain**
- ☐ **Weakness or Muscle Loss**
- ☐ **Balance Deficits**
- ☐ **Skin or Rash Symptoms**
- ☐ **Sexual Dysfunction**
- ☐ **Shortness of Breath**
- ☐ **Headaches**
- ☐ **Low Energy**

What other areas would you like to see improved? (Check all that apply)

- ☐ **Fitness & Performance**
- ☐ **Accelerated Healing**
- ☐ **Blood Flow/ Heart Condition**
- ☐ **Body Composition & Beauty**
- ☐ **Mood & Relaxation**
- ☐ **Inflammation**
- ☐ **Stress or Anxiety**
- ☐ **Weight Loss and Diet**
- ☐ **Energy**
- ☐ **Mobility/ Flexibility**
- ☐ **Anti- Aging**
- ☐ **Sexual Function**
- ☐ **Disease Prevention**
- ☐ **Immune Function**

At the end of your current healing cycle how would you like your activity and body to feel and function? Are there any specific activities you want to be doing?

_____

_____

_____

_____

_____

Consent for Evaluation and/or Treatment

At Acadiana Pain & Performance we strive to provide the most advanced and effective treatment available for healing pain and improving performance. This often integrates highly advanced treatments including medical dry needling, electro-dry needling, manipulation of spinal or peripheral joints, and myofascial release of tissues, active release of muscles, and corrective movements or therapeutic exercises. These advanced treatments offer our patients a better way to heal, resolve pain and improve function. As with many advanced procedures they do carry the possibility of unwanted side effects that you should be made aware. The most common side effect of treatment is mild soreness or bruising that resolves within 24-48 hours. A very small percentage of patients (less than one percent) may experience more significant side effects. This depends on the type of condition you have and how long you have had it.

With all manual therapies (massage, mobilization, and manipulation) side effects of bruising; muscle, tendon, ligament strains, bone fracture or strain are all possible. The most serious risk with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. It can occasionally result in a more severe puncture that could require hospitalization and further treatment. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. In the very rare instance (from one in one million to one in ten million) serious neurological damage may occur as a result of this type of treatment.

We take every precaution in our diagnosis and treatment to minimize these unfortunate occurrences. Although we offer spinal manipulation with the utmost confidence in its proven benefits, you have the choice to decide not to have this type of treatment. There are other forms of treatment available to you here, including; soft tissue therapy, electrical therapy, and mobilization, among many others.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Patient/ Parent/Guardian signature: _____

Patient/ Parent/Guardian Printed Name: _____

Date: _____

Emergency Contact: _____

Relationship to patient: _____

Emergency Contact Number: _____

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment. In addition, all questions proposed by the patient, have been fully answered at this time. Pursuant to that, it is my understanding that the patient/relative/guardian, fully understands what I have explained and answered.

Physical Therapist Signature:_____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____hereby authorize PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB and my Doctor of Physical Therapy and their therapists to release medical information contained in my/the patient's records to any necessary insurance carrier(s) and/or employer(s) and/or organizations(s), for the purpose of obtaining information and /or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of the records may also be sent to referring physician(s) at the request of the physicians treating me/the patient. Unless noted below, medical records released may include diagnostic and therapeutic information.

Withhold from release: (please specify, if any):_____

This consent will remain in force for a reasonable time to collect for medical charges. This authorization is revocable except to the extent that action has been taken in reliance thereon.

Information is disclosed from records whose confidentiality is protected by Federal or State law. Federal regulations or State law prohibit making any further disclosure of HIV antibody/substance abuse information without the specific written consent of the person to whom it pertains, or as otherwise permitted by Federal/State law.

ASSIGNMENT OF INSURANCE BENEFITS: I assign payment directly to PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB, the insurance benefits otherwise payable to me. I understand I am financially responsible to PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB for charges not paid by this assignment and that I will assist in the collection of my insurance should there be any delay in payment. If my insurance payment has not been received by PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB within 30 days of billing, I agree to actively and vigorously pursue collecting the insurance payment for PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB. If my insurance has not paid within 45 days of discharge or receipt of treatment from PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB, I understand the entire balance becomes due. THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE.

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or a related Medicare claim. I hereby authorize payment, directly to PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB, for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payment as may be due me from third party payers. I agree to execute such documents a may be necessary to apply for and obtain payment.

INSURANCE RECORD OF UNDERSTANDING: Your insurance company may require pre-authorization, usually through your physician, to determine which service(s) they will pay for. Your insurance company may not pay your claim or may reduce your benefits if you do not provide us with a proper authorization. As indicated on the card/document the phone number to call is _____. After the pre-authorization is obtained, additional information may be required by your insurance company for your entire visit to be covered.

(I understand that if I do not obtain the proper authorization, I will personally pay any penalty up to the total charges for the services received.)

THIRD PARTY LIABILITIES: If permitted by law and/or contract PAIN AND PERFORMANCE REHAB, INC. d/b/a ACADIANA PAIN & PERFORMANCE REHAB may file and enforce a lien upon third party claims to insurance.

Patient/ Parent/Guardian signature: _____

Patient/ Parent/Guardian Printed Name: _____

Relation, (if other): _____

Date: _____

Cancellation/No-Show Compliance Policy

Patient Name: _____ Date: _____

Thank you for choosing **Acadiana Pain and Performance Rehab** to provide your therapeutic, rehabilitative, and physical therapy needs! We strive to give each of our patients the highest level of care they deserve. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. If it is necessary that you change your scheduled appointment, ***we require that our office be notified by 3 PM the day prior to your scheduled appointment; if on a Monday we require to be notified by 3 PM the Friday before,*** so that we can offer your appointment time to another patient in pain.

Patient Initial _____I understand that appointment cancellations after the cut off time **or** not within business hours may be subject to a $50.00 cancellation fee at Acadiana Pain & Performance Rehab's discretion.

Patient Initial _____I understand that if I have an appointment with Acadiana Pain & HERO Health Spa and cancel will be subjected to a $75.00 fee.

Patient Initial _____I understand that if I come to appointment with Acadiana Pain but cancel same day for advanced services in HERO Health Spa I will be subjected to a $25.00 cancellation fee.

Patient Initial _____I understand that multiple appointment cancellations after the cut off time/no-shows may lead to termination of the current Plan of Care.

Patient Initial _____I give consent to Acadiana Pain & Performance to charge my credit card on file for the **ANY fees** if I fail to cancel or reschedule any appointment before the cut off time or no-show on any appointment.

By signing below, I am stating that I have read and I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no-shows.

Patient/Guardian Signature: _____

Social Media Consent/ Release Form

For news media, promotional materials, written articles, research and/or photographs

I, _____, authorize Acadiana Pain and Performance Rehab to use my
(Print First & Last Name)
photo and/or information related to my experiences at Acadiana Pain and Performance Rehab. I understand this content may be used in various social media platforms, electronic publications, audiovisual publications, promotional materials, and advertising presentations.

X_____My consent is freely given as a public service to Acadiana Pain and Performance Rehab, without
(initial)
expecting payment.

X_____I release Acadiana Pain and Performance Rehab from any and all liability which may arise from the use of
(initial)
such news media stories, promotional materials, written articles, videos/ photographs.

I give consent that:

_____I do not give consent for my image to be used at all.

- ☐ My full name be used
- ☐ My first name ONLY be used
- ☐ No name be used

I understand that I can revoke this release at any time in writing and that the use of any of my photos or other information authorized by this release will immediately cease.

X_____ _____
(Signature) (Date)