EMPLOYER: _____OCCUPATION: _____

If not working, length of time since last worked: _____(days, months, years)

Are you currently under any work restrictions from your doctor? Yes No
Nature of restrictions: _____

CURRENT HISTORY

Describe your present injury or complaint? _____

_____

Do you have any additional injuries or complaints? _____

_____

Date of injury/onset: _____/_____/_____ Date of surgery: _____/_____/_____

What caused the current condition? Accident Overuse Sports Injury Surgery Unknown Work Other

_____

Rate the intensity of your pain: **B** = at its best **W** = at its worse **A** = average
(for example, if on your best days your pain level is 2, write the letter "B" on the 2 on the scale below)

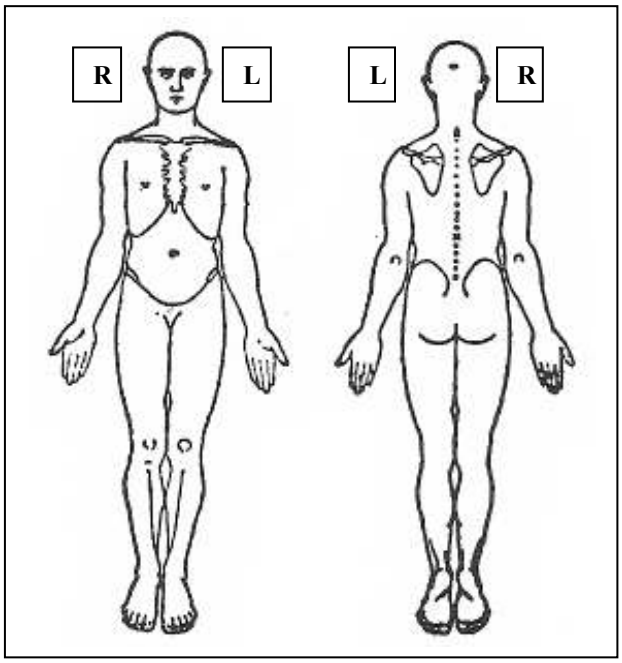
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Is your pain: Constant or does it Come and go

Is your pain getting: Better Worse Not changing

On the diagram to the right;
Please indicate where you have pain:

a. **Circle** - areas of pain
b. **XX** - areas of numbness/tingling
c. //// - areas of muscle tightness/soreness



What position or activity eases your pain the most?

_____

What position or activity aggravates your pain the most?

_____

Current Activity level: 0% = bedridden 100% = able to perform all pre-injury activities

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

MEDICAL HISTORY

Check (✓) any of the conditions below that you have experienced:

Musculoskeletal
Carpal tunnel syndrome
Fibromyalgia
Osteoarthritis
Rheumatoid Arthritis
Sciatica
Spinal Dysfunction
Sprains/Strains
Tendonitis
Thoracic Outlet Syndrome
TMJ Dysfunction

Nervous
Headaches
Multiple Sclerosis
Numbness/Tingling
Parkinson's Disease
Peripheral Neuropathy
Post Polio Syndrome
Seizures
Shingles
Stroke

Circulatory
Aneurysm
Clotting Disorder
Diabetes
Heart Attack
Heart Disease
High Blood Pressure
Pace Maker
Peripheral Artery Disease
Varicose Veins

Lymph and Immune
AIDS, HIV
Chronic Fatigue Syndrome
Edema
Hodgkin's disease
Lymphoma
Lupus

Respiratory
Asthma
COPD
Emphysema
Tuberculosis

Integumentry
Boils
Eczema
Fungal Infection
Skin Cancer
Warts

Digestive
Diverticulitis
Gallstones
Heartburn
Hepatitis
Irritable Bowel Syndrome
Ulcerative Colitis

Miscellaneous
Allergies
Cancer (other then above)
Changes in Bowel Habits
Changes in Bladder Habits
Dizziness/Fainting
Fever/Chills/Night Sweats
Mental Disorder
Metal Implants
Serious Personal Injuries
Severe Night Pain
Unexplained Weight Loss

How is your general health? Poor Fair Good Excellent

What is your current stress level? Low Average High

Are you currently or have you recently taken any of the following medications? Antibiotics Anti-inflammatories

Blood Thinners Heart Meds Muscle Relaxants Pain Killers Steroids (cortisone) Other

_____ _____

_____

Is there any chance you may be pregnant at this time? Yes No

Since the onset of this problem, have you had any of the following interventions?

Surgery MRI CT Scan X-Rays Injections Nerve Blocks Bone Scan Blood Tests Massage

Chiropractic Physical Therapy Acupuncture Other

_____

PACE WEST PHYSICAL THERAPY

Pace West Physical Therapy will to verify coverage with your insurance company in advance of your appointment. **However, it is important for you to refer to your insurance policy to verify details, including limitations, regarding your coverage for outpatient physical therapy.** Insurance benefits quoted are not a guarantee of payment, but only a description of your potential benefits. Final determination of benefits will be made by your insurance company upon the receipt of submitted claims.

Patients or Guarantors are responsible for paying co-pays, co-insurance, deductibles, non-covered supplies and non-covered services, services which exceed benefit limitations, and no shows and/or late cancellations. Copayments and payments for supplies and non-covered services are due at the time of service.

After your primary carrier responds to your claim, we will bill your secondary for the remainder. You will be billed for any patient responsibility after all claims are processed.

If you are treating as a result of an auto accident and have medical payments coverage, we will bill your auto insurance carrier directly. If your medical payments coverage is exhausted, we will subsequently bill your health insurance carrier. If you are treating as a result of a Worker's Compensation accident, your Worker's Compensation carrier will be billed directly.

Pace West Physical Therapy reserves the right to charge **$72 for no show appointments or any cancellations** not made 24 hours in advance of appointment time.

If collection and/or legal services are required to obtain payment, patient (or parent, if patient is a minor) is responsible for all costs reasonably incurred including attorney fees, court costs, collection fees and interest at a rate of 1 ½% per month.

I have read the above payment policy, and I understand my responsibilities.

_____ _____

Patient or authorized person (signature) Date

- I authorize the release of any medical information necessary to process the claim for services rendered. I further authorize payment of medical benefits directly to Pace West Physical Therapy. _____ Patient Initials
- We stringently maintain the privacy of patient health information. A Notice of Privacy Policies is posted in the waiting room. If you wish to review our privacy practices, please ask the front desk receptionist to provide you with a copy of our policy.
- I hereby acknowledge that I consent to treatment at Pace West Physical Therapy. _____ Patient Initials
- ***I verify that the above information is to the best of my knowledge accurate and complete.***

_____ _____

Patient or authorized person (signature) Date

1800 30th Street, Suite 215
Boulder, CO 80301
303-546-9201
Fax 303-545-5080

www.pacewestpt.com

Trevor Pace PT, DPT, MS
Chris West MPT
Darcy Vanderbie Pace MPT
Paul Fohrman PT, OCS
Katie Andrews DPT

PATIENT INFORMATION

Today's Date _____

Patient's full legal name_____ Gender M _____ F _____ Other___

Address_____City_____State_____Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

SS#_____ Date of Birth_____

Emergency Contact_____ parent spouse friend other: _____
Phone _____

How did you hear about us? Doctor Insurance Plan Internet Phone Book Friend Family
Other: _____

Ethnicity: Hispanic Non-Hispanic Declined.
Primary Language: English Spanish Other Arabic Cantonese French German Hindi Italian
RACE: American Indian Asian Black Native Hawaiian White Other Declined

INJURY INFORMATION

Date of Injury_____ Referring Physician _____ Phone_____

Is this injury accident related? Yes No

Did your injury occur: In a Car At Work At Home At a business During Recreation

For Auto Accidents, do you have medical payments coverage? Yes No Limits: _____
Are you represented by an attorney? Name:_____ Phone:_____

MINOR CONSENT: I hereby authorize Pace West Physical Therapy to provide treatment to my child or ward.

Print Name: _____ Relationship:_____
Signature: _____
Date:_____

PACE WEST PHYSICAL THERAPY

CONSENT AND RELEASE FOR TRIGGER POINT DRY NEEDLING PROCEDURE (TDN)

This form is a consent form and general release of medical liability for the TDN procedure. By signing this form, you are agreeing not to hold Pace West Physical Therapy or its staff liable for any complications that may arise from the usual application of this procedure. Prior to receiving TDN you will be "verbally consented." This means you will be asked if you want to proceed. If you state "yes," you will not be asked to sign this form again. This form will be kept on file. You may request a copy of this consent form for your records.

DESCRIPTION OF PROCEDURE: During treatment for many of our patients, we commonly use a technique referred to as **Trigger Point Dry Needling (TDN).** In many cases, TDN can be helpful in resolving sub-acute and chronic pain. TDN may be very effective for your medical condition.

TDN involves placing a tiny acupuncture needle into the muscle in order to release shortened bands of muscle and decrease trigger point activity. This can help resolve pain, release muscle tension, and promote healing. This is **not** traditional Chinese Acupuncture, but instead a medical treatment that relies on a medical diagnosis to be effective. All Physical Therapists at Pace West Physical Therapy have met the requirements for Level I and Level II TDN training and have years of experience in performing the procedure.

RISKS OF PROCEDURE: While complications from receiving TDN are rare in occurrence, they are real and must be considered prior to giving consent for treatment. The most serious risk associated with TDN 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 unless you are taking a blood thinner. *Additional possible complications include possible increased pain or other symptoms.* As the needles are very small and do not have a cutting edge, the likelihood of any significant trauma from TDN is minimal.

CHARGES FOR TRIGGER POINT DRY NEEDLING: TDN is a procedure which requires additional equipment, expertise, and liability, and in most cases is NOT covered by health insurance. The fee for the procedure is **$25.00 per session** or **five pre-paid sessions for $100.00**. This fee is in addition to your per visit copayment, coinsurance or deductible. There is no additional charge for TDN if you are not using health insurance coverage, and are paying out of pocket. If your care is covered by an auto accident or liability claim, TDN will be billed to your liability insurance carrier.

Name of Patient: _____

Signature of Patient or Guardian: _____ Date: _____

Therapist's Signature: _____ Date: _____