BODYWISE
PHYSICAL THERAPY

Patient History Form

Name:_____ Date of Birth:_____

Have you recently noticed any of the following symptoms? Check all that apply.

- ☐ Change in bowel/bladder function
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance while walking
- ☐ Changes in appetite
- ☐ Fevers/chills/sweats
- ☐ Weakness/fatigue
- ☐ Difficulty swallowing
- ☐ Weight loss/ gain
- ☐ Headaches
- ☐ Feeling depressed
- ☐ Extreme anxiety

Have you ever been diagnosed with any of the following conditions? Check all that apply.

- ☐ Cancer (type?)_____
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Diabetes
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Kidney/liver problems
- ☐ Pacemaker inserted
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Other_____
- ☐ Anemia
- ☐ Lung problems
- ☐ Thyroid problems
- ☐ Epilepsy
- ☐ Stomach ulcers
- ☐ Rheumatoid arthritis
- ☐ Other_____

Please list any medications you are currently taking (including any blood thinners/anticoagulants):

_____

_____

Please list any allergies: **Are you latex sensitive? YES/NO**

_____

_____

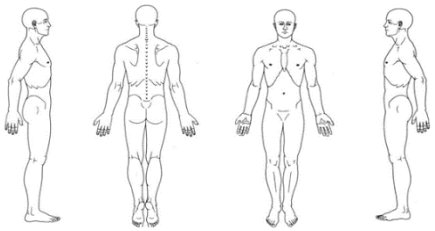
Do you smoke? YES/NO **If yes, how many packs per day? _____** **Are you currently pregnant? YES/NO**

Please list any past surgeries or hospitalizations (including dates):

What is your main complaint? _____ When did your symptoms start? _____
What are your symptoms? _____What makes it worse? _____
What makes it better? _____ Are there any activities you are unable to do? _____
Have you been treated for this issue before? Where/When? _____
Describe your pain (dull, achy, sharp, constant, intermittent, only with certain movements, etc.):

_____

What are your physical therapy goals? _____
On a scale from 0 to 10, how would you rate your pain? (0 - no pain, 10 - worst pain ever) please circle: 0 1 2 3 4 5 6 7 8 9 10



Body Chart: using the key below, please mark the location of your pain and type of pain:
X sharp stabbing pain
O dull achy pain
…. numb/tingling
/// throbbing
=== burning

Patient Signature: _____ Date: _____

4440 Arapahoe Ave, Ste 101, Boulder, CO 80303
Phone: (303) 444-2529 Fax: (303) 444-2563 www.bodywisept.com

BODYWISE
PHYSICAL THERAPY

Patient Financial Agreement

Bodywise Physical Therapy is committed to serving our patients with professionalism and courtesy, and we expect the same from our patients. This includes being on time for your appointment and calling to cancel your appointment if you cannot make it. It also includes financial responsibility such as making your copayment or deductible payments at the time of your office visit. We accept cash, check, and all major credit cards.

Our practice accepts insurance from most major insurance companies. As a courtesy, we will verify and review you insurance coverage benefits, estimate your insurance payments, and the approximate amount of patient responsibility. Though the patient is liable for any costs not covered under his/her insurance plan, we will assist you to maximize these benefits.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary/supplemental insurance benefits, including any referral documents from other medical providers. Current identification and insurance benefit cards are to be presented during your **first** appointment. As a courtesy to our patients, we submit all primary and secondary/supplemental claims.

FOR ALL MEDICARE PATIENTS: A doctor's referral is REQUIRED. Please present this at your first appointment to avoid any denial of claims or delay in payment.

FOR *ALL* PATIENTS: We require one upfront $20 supply fee to be paid during your first appointment.

I understand that my signature authorizes the payment of medical benefits from my insurance company to *Bodywise Physical Therapy.* My signature also authorizes the release of any medical information necessary to process my insurance claim(s).

Patient Signature: _____

Cancellation Policy

Bodywise Physical Therapy requires a strict **24-hour cancellation.** This ensures that all of our patients have the same opportunity to receive the highest quality of care, service, and personal attention.

Here is our breakdown of fees for any late cancelled/no-showed appointments:

- 1st Late Cancel/No Show: **FEE WAIVED**
- 2nd Late Cancel/No Show: **$75**
- 3rd Late Cancel/No Show: **$90**
- 4th or more Late Cancel : **$100**

Print Name: _____
Patient Signature: _____ Date: _____

4440 Arapahoe Ave, Ste 101, Boulder, CO 80303
Phone: (303) 444-2529 Fax: (303) 444-2563 www.bodywisept.com

BODYWISE
PHYSICAL THERAPY

Informed Consent for Physical Therapy Services

Physical therapy is a patient care service used to manage a wide variety of conditions. Services are provided to individuals of all ages, regardless of gender, color, religion, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury, and disability, by examination, diagnosis, prognosis, and intervention by use of rehabilitative procedures. Such procedures include but are limited to: mobilization, massage, therapeutic exercise, and dry needling. Any modalities used are focused on achieving rehabilitative and functional goals, within the realm of physical therapy.

Response to physical therapy intervention varies from person to person, therefore it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. *Bodywise Physical Therapy* does not guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to refuse any part of treatment, at any time, regardless of circumstance. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, diagnosis, symptoms and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy. I agree to cooperate, participate, and comply with any physical therapy procedures within the established plan of care. **I also authorize the release of my medical information to any relevant third parties.**

Print Name: _____

Patient Signature: _____ Date: _____

4440 Arapahoe Ave, Ste 101, Boulder, CO 80303
Phone: (303) 444-2529 Fax: (303) 444-2563 www.bodywisept.com

BODYWISE
PHYSICAL THERAPY

Automatic Payment Consent Form

As a courtesy, *Bodywise Physical Therapy* will retain a credit/debit/HSA card on file for active patients. This information is kept strictly confidential and will only be used for payment of fees to *Bodywise Physical Therapy.* Our patients can choose to automatically pay copays, late cancel fees, supply fees, and deductibles using this stored payment information. If you would like us to automatically bill your card, please sign below – **this is optional.**

Authorization:

I authorize *Bodywise Physical Therapy* to charge my credit/debit/HSA card for the balance of fees. I understand that if the amount charged is greater than $100, I will be notified of the amount my card is being charged for. All receipts and itemized statements will be provided to me upon request.

Cardholder Name:

_____

Cardholder Signature:

_____

Card Number:

_____

Billing Zip Code:

_____

CVC Security Code:

_____

Expiration Date:

_____

Card Type (please circle one):

VISA **MASTERCARD** **AMEX** **HSA** **DISCOVER**

4440 Arapahoe Ave, Ste 101, Boulder, CO 80303
Phone: (303) 444-2529 Fax: (303) 444-2563 www.bodywisept.com

BODYWISE
PHYSICAL THERAPY

Trigger Point Dry Needling Waiver

IMT/TDN involves placing a small needle into the muscle at the trigger point which is typically in an area where the muscle is tight and may be tender. This is done with the intent of causing the muscle to contract and then release, improving the mobility of the muscle and therefore decreasing pain and tension. IMT/TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. As with any treatment, there are possible complications. While these complications are rare in occurrence, it is recommended that you read through the possible risks prior to consenting to treatment.

Risks may include bruising, infection, and nerve injury. Bruising is a common occurrence and is not a concern unless you are taking blood thinners. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants, or have any other conditions that may have adverse effects to needle punctures. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT/TDN is highly unlikely.

The most serious risk associated with IMT/TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may only require a chest x-ray, and no further treatment, as this condition can resolve on its own. The symptoms include pain and shortness of breath, that can last from several days to weeks. This is a rare complication, and in skilled hands, it should not be a concern. If a pneumothorax is suspected, you should seek medical attention from your primary care provider or go to your local emergency room.

Print Name: _____

Patient Signature: _____ Date: _____

4440 Arapahoe Ave, Ste 101, Boulder, CO 80303
Phone: (303) 444-2529 Fax: (303) 444-2563 www.bodywisept.com