BOUNDLESS
PHYSICAL THERAPY & SPORTS PERFORMANCE

PHYSICAL THERAPY PATIENT INTAKE FORM

Patient Information

Name: Today's date:

Date of birth: Gender: ☐Male ☐Female ☐Non-binary

Address: Phone number:

City/State/Zip: Email address:

Employer: ☐Full-time ☐Part-time ☐Other:

How did you hear about us: ☐Google ☐Yelp ☐Website ☐Self-referred ☐Social media

☐Friend/Family ☐Other

Purpose of Visit

Injury: Injury date:

Using the numeric pain rating scale from 0-10 (0 = no pain, 10 = worst pain), please rate the following:

Current pain: ; best pain within the last 24 hours: ; worst pain within the last 24 hours:

Have you had any treatment for this issue? ☐Yes ☐No If yes, please describe:

Have you had any of the following: ☐MRI ☐X-Ray ☐CT Scan

Have you had surgery for this condition? ☐Yes ☐No If yes, date of surgery:

Type of surgery:

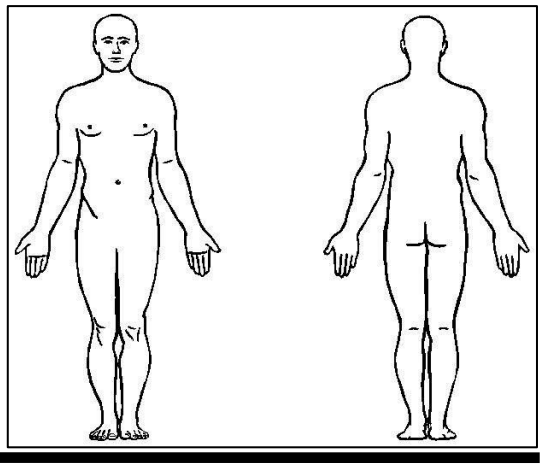
Body Chart: *To mark the chart, use the drawing or markup tool in your PDF app.*

Please mark the areas where you feel the symptoms on the chart to the right with following symbols to describe your symptoms:

↓ Shooting/sharp pain
O Dull/aching pain
||| Numbness
= Tingling

Or describe your symptoms:

My symptoms currently:
☐Come and go
☐Are constant
☐Change with activity, but constant



Emergency Contact Information

Name: Relationship: Phone number:

☐**I certify that the above information provided by me is true and correct to the best of my knowledge.**

Printed Name | Patient/Guardian Signature | Date

Type your full name to sign electronically

Phone: (480) 269-1668 **E-mail:** phil@boundlessptsp.com

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PHYSICAL THERAPY MEDICAL SCREENING QUESTIONNAIRE

Name: _____ **Date:** _____ **Age:** _____

Do you have a pacemaker? ☐ **YES** ☐ **NO**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ **YES** ☐ **NO**

ALLERGIES: List any known allergies including medication(s): _____

Have you RECENTLY noted any of the following? Check all that apply.

☐ Fatigue	☐ Numbness or tingling	☐ Constipation	☐ Falls
☐ Fever/chills/sweats	☐ Muscle weakness	☐ Diarrhea	☐ Changes in bowel or bladder function
☐ Nausea/vomiting	☐ Dizziness/lightheadedness	☐ Shortness of breath	
☐ Weight loss/gain	☐ Heartburn/indigestion	☐ Fainting	☐ Difficulty maintaining balance while walking
☐ Headaches	☐ Difficulty swallowing	☐ Cough	

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

☐ Cancer	☐ Pneumonia	☐ Bladder/urinary tract infection	☐ Ulcers
☐ Heart condition	☐ Lung condition	☐ Pelvic inflammatory disease	☐ Bone or joint infection
☐ Chest pain/angina	☐ Tuberculosis	☐ Depression	☐ Liver condition
☐ High blood pressure	☐ Asthma	☐ Thyroid condition	☐ Hepatitis
☐ Circulation problem	☐ Rheumatoid arthritis	☐ Diabetes	☐ Sexually transmitted disease/HIV
☐ Blood clots	☐ Other arthritic condition	☐ Osteoporosis	
☐ Stroke	☐ Eye problem/infection	☐ Multiple sclerosis	☐ Chemical dependency (i.e. alcohol, opioids)
☐ Anemia	☐ Kidney problem/infection	☐ Epilepsy	

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? Check all that apply.

☐ Cancer	☐ Diabetes	☐ Depression	☐ Thyroid condition
☐ Heart condition	☐ Stroke	☐ Tuberculosis	☐ Blood clots

During the past month, have you been feeling down, depressed, or hopeless? ☐ **YES** ☐ **NO**
During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ **YES** ☐ **NO**
If yes to either, is this something with which you would like help? ☐ **YES** ☐ **NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

Have you ever taken steroid medications for any medical conditions? ☐ **YES** ☐ **NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ **YES** ☐ **NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

Printed Name _____ Patient/Guardian Signature _____ Date _____

Type your full name to sign electronically

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CONSENT TO TREAT FORM

We utilize a variety of procedures and modalities to help us to try and improve your function. There are risks and benefits associated with physical therapy. Responses can vary from person to person and it is not always possible to predict what response you will have from physical therapy. As such, we are not able to guarantee that the desired results will be achieved, nor can we guarantee what your reaction will be to said treatment.

Although it is not the typical outcome, risks associated with physical therapy include pain, injury, or aggravation of prior existing conditions. It is your right to ask your physical therapist what type of treatment to expect. It is your right to ask what are the risks and benefits for each treatment. You have the right to decline any portion of treatment prior to or during treatment.

Benefits associated with physical therapy include an improvement in symptoms and an increase in ability to perform daily activities. You may experience an increase in strength, endurance, flexibility, and awareness in your movement. Additional benefits can include decreased pain and discomfort. You should gain a greater knowledge about managing your condition and the resources available to you.

Exercises are likely to be included in your plan of care, which has inherent physical risks associated with it. If you have questions about exercise or the risks and benefits of specific exercises, you are encouraged to ask your physical therapist.

I authorize the provider in charge of the care of the patient listed below, to provide diagnosis and treatment of services while a patient at **Boundless Physical Therapy & Sports Performance**.

Initials _____

I authorize the release of any medical information necessary to process payment for services rendered.

Initials _____

I acknowledge that treatment has been explained to me and that all my questions have been answered. I understand the risks associated with physical therapy and recognize that I am free to seek other opinions relating to my health. I agree to accept the treatment prescribed to me and I wish to proceed.

Initials _____

Printed Name	Patient/Guardian Signature *Type your full name to sign electronically*	Date

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DRY NEEDLING CONSENT FORM

Dry needling (DN) involves placing a small monofilament needle in a muscle in order to release shortened bands of muscles by causing the muscle to contract and then release to decrease trigger point activity. This response improves flexibility of the muscle, which can help resolve pain to promote healing. Modalities such as electrical stimulation can be used in conjunction with dry needling to stimulate neuromuscular activity and promote blood flow, which can improve muscle activity and sensation to affected areas. DN is an effective and valuable treatment for musculoskeletal pain. This is not traditional Chinese acupuncture and is not intended to stimulate any auricular acupuncture points. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to several weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include excessive bleeding (causing a bruise), infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely. The needles are sterile and our therapists utilize clean blood borne pathogen precautions in order to minimize the chance of infection.

Please answer the following questions:

1.	Have you ever fainted or experienced a seizure?	☐ Yes	☐ No
2.	Do you have a pacemaker or any other electrical implants?	☐ Yes	☐ No
3.	Are you currently taking anticoagulants (i.e. Aspirin, blood thinners)?	☐ Yes	☐ No
4.	Are you currently taking antibiotics for an infections?	☐ Yes	☐ No
5.	Do you have a damaged heart valve, metal, or other risk of infection?	☐ Yes	☐ No
6.	Are you pregnant?	☐ 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, C, HIV, or any other infectious disease?	☐ Yes	☐ No

Patient's Consent

I have read, or been read, and understand the above information, and hereby give consent for DN procedures to be performed on me by a DN certified therapist at **Boundless Physical Therapy & Sports Performance**. All DN certified physical therapists have met the requirements set by the Arizona State Board of Physical Therapy for the safe use of this intervention technique. This consent may be revoked at any time verbally or in writing.

Printed Name	Patient/Guardian Signature *Type your full name to sign electronically*	Date

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STATEMENT OF FINANCIAL POLICY

Thank you for selecting **Boundless Physical Therapy & Sports Performance** as your physical therapy provider. We are dedicated to giving each patient the best one-on-one care available with the personal attention you deserve. A copy of this form is available upon request.

Explanation of Payment

All payment will be provided to **Boundless Physical Therapy & Sports Performance**. If you would like to submit claims to your third-party payer, we will provide you with a "superbill" detailing all treatment received. We ***do not*** submit claims on your behalf. It is not guaranteed that you will receive reimbursement from your health insurance carrier, and you are ultimately responsible for the entire balance of your account.

Initials _____

No-Show/Cancelation Policy

We realize that, on rare occasions, you may need to reschedule or cancel your appointment. Please contact our office at (480) 269-1668 ***at least 24 hours before your scheduled appointment*** to cancel and reschedule your appointment. A fee of $50 may be charged if you fail to do so.

Initials _____

Financial Responsibility

I understand that it is my responsibility to verify my out-of-network benefits for physical therapy, not Boundless Physical Therapy & Sports Performance. I understand that Boundless Physical Therapy & Sports Performance cannot guarantee coverage or benefit levels. I agree to be personally and fully responsible for payment of services rendered (as outlined in this form). Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney fees and collection expenses.

Initials _____

Please be advised that all payments are due at time of service, although there may be some circumstances in which payments plans are offered for package purchases. These payment plans require monthly installments, and the full amount of the package is paid within 3 months. We accept Visa/Mastercard/Discover/American Express, checks, and cash. A fee of $25 will be charged on all returned checks.

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NOTICE OF PRIVACY PRACTICES

Release of Information

I authorize any physician, hospital, school, referring agency or other person who has records pertaining to treatment at **Boundless Physical Therapy & Sports Performance** to release such records, upon request, to our facility. Furthermore, I authorize **Boundless Physical Therapy & Sports Performance** use or release of any of my records it may have to third-party payers, government agencies, healthcare providers or other organizations that may assist them in meeting my healthcare needs. I may revoke this authorization in writing at any time and that such revocation will be effective as of the date the written revocation is received by **Boundless Physical Therapy & Sports Performance**.

Privacy Practices

You are entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). During the course of treatment, we collect paper and/or electronic records describing your health history, symptoms upon examinations and test results, diagnoses, treatments and any plans for future care or treatment.

You understand that this information serves as:

- A basis for planning my care and treatment
- A means by which third-party payers can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

You have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of your health information for directory purposes
- The right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment or health care operations

We treat this information as confidential and realize the importance of protecting that information. A complete copy of our HIPAA Privacy Practices is available upon request. By signing below, I agree that I have read the above information and fully understand and accept the terms of this consent.

Printed Name	Patient/Guardian Signature *Type your full name to sign electronically*	Date

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ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

HIPAA

I acknowledge that I have received a copy of the Boundless Physical Therapy & Sports Performance Notice of Privacy Practices, containing a complete description of the uses and disclosure of my health information. This is simply an acknowledgement of receipt and nothing more.

Printed Name	Patient/Guardian Signature *Type your full name to sign electronically*	Date

CONSENT FORM, APPOINTMENTS, AND FINANCIAL POLICY

I acknowledge that I have a received a copy of the Boundless Physical Therapy & Sports Performance Patient Information and Consent Form, containing a complete description of the benefits and risks associated with physical therapy, attendance policies, and financial policies. This is simply an acknowledgement of receipt and nothing more.

Printed Name	Patient/Guardian Signature *Type your full name to sign electronically*	Date

Phone: (480) 269-1668 **E-mail:** phil@boundlessptsp.com