WEST BILLINGS
Physical Therapy & Sports Medicine
3307 GRAND AVENUE, STE 203 • BILLINGS, MT 59102-6551

CONSENT FOR TREATMENT

I voluntarily agree to receive treatment by the staff of West Billings Physical Therapy, either in person or via telehealth.

I understand and agree that I will participate in my treatment plan, and that I may discontinue treatment and/or withdraw my consent for treatment at any time.

I understand that staff of West Billings Physical Therapy may discontinue treatment at their discretion.

_____

Patient Legal Name – Please print

Patient DOB: _____

Current Address _____

_____

Current Phone # _____

Would you like an appointment reminder sent to your Email? If Yes, please print clearly

Email: _____

Is this injury the result of an auto accident or a work comp claim? Y N

_____ _____

Patient Signature or Guarantor if under 18 Date

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MEDICAL SCREENING QUESTIONNAIRE

DATE: _____

NAME: _____

DATE OF BIRTH: _____ AGE: _____

GENDER: M F SMOKER: Y N

PREGNANT: Y N TRIMESTER: 1ST 2ND 3RD

OCCUPATION: _____

WORK RELATED OR MVA: Y N

DESCRIBE YOUR EXERCISE ROUTINE:

_____

Past Surgical History with Dates

_____

_____

_____

Current Medications

_____

_____

_____

Have you had any Xrays, MRI or other imaging done?
Y N
Where?_____

PAST MEDICAL HISTORY – HAVE YOU BEEN TOLD YOU HAVE OR HAD:

CANCER	Y N	PACE MAKER	Y N	LUNG DISEASE	Y N
DIABETES	Y N	DEEP VEIN THROMBOSIS	Y N	ALLERGIES/ASTHMA	Y N
KIDNEY DISEASE	Y N	USED CORTICOSTEROIDS?	Y N	SEIZURES	Y N
LIVER DISEASE	Y N	OSTEOPOROSIS	Y N	ULCERS	Y N
STROKE	Y N	OSTEOARTHRITIS	Y N	ENDOMETRIOSIS	Y N
HIGH BLOOD PRESSURE	Y N	RHEUMATOID ARTHRITIS	Y N	SEXUALLY TRANSMITTED DISEASES	Y N
HEART DISEASE	Y N	FIBROMYALGIA	Y N	RECENT ILLNESS INFECTION	Y N
ANGINA/CHEST PAIN	Y N	MIGRAINES OR HEADACHES	Y N	ANY OTHER HISTORY? EXPLAIN BELOW*	Y N

*

ARE YOU CURRENTLY EXPERIENCING:

CHANGE IN HEALTH	Y N	HEADACHES	Y N
UNEXPLAINED WEIGHT LOSS	Y N	POOR BALANCE/FALLS	Y N
INCREASED PAIN AT NIGHT OR REST	Y N	DIZZINESS	Y N
FEVERS/CHILLS/NIGHT SWEATS	Y N	VISION CHANGES	Y N
NAUSEA/VOMITING	Y N	PAIN/CHANGES WITH MENSTRUATION	Y N
CHANGES WITH BOWELS OR BLADDER	Y N	NUMBNESS OR TINGLING	Y N
PAIN WITH EATING	Y N	SHORTNESS OF BREATH	Y N
DIFFICULTY SWALLOWING	Y N	DEPRESSION	Y N
CHANGES IN APPETITE	Y N	LOSS OF SENSATION ANUS/GENITALS	Y N

In the past month, have you often been bothered by feeling down, depressed or hopeless? Y N
In the past month, have you often been bothers by little interest or pleasure in doing things? Y N
Is this something with which you would like help? Yes, Today/ Yes, but not today/ No Help (circle one)

Are you currently working? Y N **Retired**

Has your pain required you to alter your work? Y N

CURRENT SYMPTOMS:

Where are you currently having symptoms? _____

What date (approximately) did your present pain begin? _____

How (gradually, suddenly, injury)?

My symptoms are currently **Getting better / Staying the same / Getting worse**

Have you received treatment for this problem? Y N **Where**_____

Have you ever had this problem before? Y N

If so, how was the problem treated? _____

How long did it take for you to feel better?_____

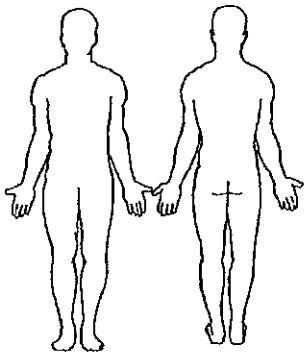
How are you able to sleep at night? **Fine / Moderate difficulty / Only with medication**

What are your goals for therapy? _____

Do you have any barriers to learning? _____

Do you have any allergies? _____

Please circle the number that best represents the severity of your pain



Average in the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Best for the past 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Worst for the past 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Does coughing, sneezing or taking a deep breath make your pain feel worse? Y N

Do activities such as bending, sitting, lifting, twisting and/or turning in bed make your pain worse? Y N

Do you have pain with bowel, bladder or sexually related activities/functions? Y N

Are you taking blood thinners? Y N If yes, is your INR stable? Y N What is your INR? _____

Do you have any known diseases or infections that can be transmitted through bodily fluids? Y N

Do you have any metal or other implanted devices? If yes, please list _____

What activities make your pain worse? _____

What activities make your pain better? _____

When do your symptoms feel the best? **AM / PM / Daytime (circle one)**

When do your symptoms feel the worst? **AM / PM / Daytime (circle one)**

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem.

1. _____
2. _____
3. _____

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HIPAA AUTHORIZATION FORM

_____ _____

Patient Name DOB

I hereby authorize West Billings Physical Therapy and Sports Medicine the use of or disclosure of my protected health information as described and may disclose such information to persons or entities listed below:

1. _____
2. _____
3. _____

All past, present and future periods of health care information may be shared.

I understand that the information used or disclosed under this authorization form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form. If signed, I have the right to revoke this authorization in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge that I will be provided a copy, upon request, of the Notice of Privacy Practices of West Billings Physical Therapy. I understand that if I have any questions regarding the notice or my privacy rights, I can contact West Billings Physical Therapy.

_____ _____

Signature of patient or responsible party Date

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Dry Needling Consent Form

Please review the following information **PRIOR** to consenting to application of dry needling techniques which is recommended by your physical therapist as a part of the physical therapy plan of care.

Dry Needling is a technique that utilizes thin, solid filament needles to treat myofascial trigger points, muscle spasms, or dysfunctional tissue.

Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure.

- You may experience an increase in pain for one to two days followed by an expected improvement in your overall symptoms.
- You may experience a general feeling of fatigue following treatment as your body requires energy to assist in healing the tissue dysfunction.
- You may experience a small bruise or localized bleeding in the region of the inserted needle.
- You may also experience any of the following during treatment: A feeling of relaxation, an increase in energy level, dizziness, nausea, sweating, or irritation at the site of needle insertion.
- A rare complication is the development of a pneumothorax. The risk is minimal with a cautious and experienced physical therapist performing the dry needling.

Indicate below if you have any of the following conditions: (circle Y or N)

Y	N	HIV/AIDS/Hepatitis	Y	N	Unstable Blood Pressure
Y	N	Current or Recent Infection	Y	N	Pacemaker
Y	N	Use Blood Thinners	Y	N	Cancer
Y	N	Current use of Immunosuppressant Medication	Y	N	Diabetes
Y	N	Phobia of Needles	Y	N	Currently Pregnant

I have read this form and I understand the risks involved with dry needling therapy. I understand that the physical therapist will answer any questions or concerns before proceeding. I agree to advise my physical therapist of any and all changes in my physical condition, whether or not I believe these changes will affect my physical therapy plan of care.

I consent to dry needling treatment by my physical therapist

Print Patient Name _____ **Date**_____

Patient (Guarantor) Signature_____