ACT NOW
PHYSICAL THERAPY AND CONCUSSION

2230 Indianapolis Blvd
Whiting, IN 46394
(219) 655-8994

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Email Address:			
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	

Chose Clinic Because/ Referred to Clinic by Dr.: ☐ Insurance Plan ☐ Word of Mouth:

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Phone: ( ) -
Regular Dr./PCP	Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:		
Subscriber's Name (If different):		Birth Date: / /
ID. #:	Group/Policy #:	Policy Holder's SSN:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth Date: / /
ID. #:	Group/Policy #	
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto:	☐ Labor & Industries:		
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

IN CASE OF EMERGENCY

Name of Local Relative or Friend:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -
Please provide the name of the person(s) to whom Act Now Physical Therapy And Concussion Management may disclose health information		
Name:	Relationship to Patient:	Phone: ( ) -
May we send an email or leave messages regarding appointments or treatment on your answering machine? ☐ Yes ☐ No		

I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s). Additionally, I authorize my insurance benefits be paid directly to Act Now Physical Therapy And Concussion Management and authorize said practice to release any information required to process my claim. I understand that I am financially responsible for any remaining balance.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM **Patient Name**

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
Other:		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			
	☐ Other			

What types of exercise do you perform? _____

What things cause stress in your life?

Are you taking any seizure medication? ☐ Yes ☐ No If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ Yes ☐ No If yes list name: _____

List all medications you are currently taking: _____

List all surgeries (including dates): _____

Are you pregnant? ☐ Yes ☐ No What week? _____

Have you had any injuries related to work? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had any auto accidents? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ Yes ☐ No Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

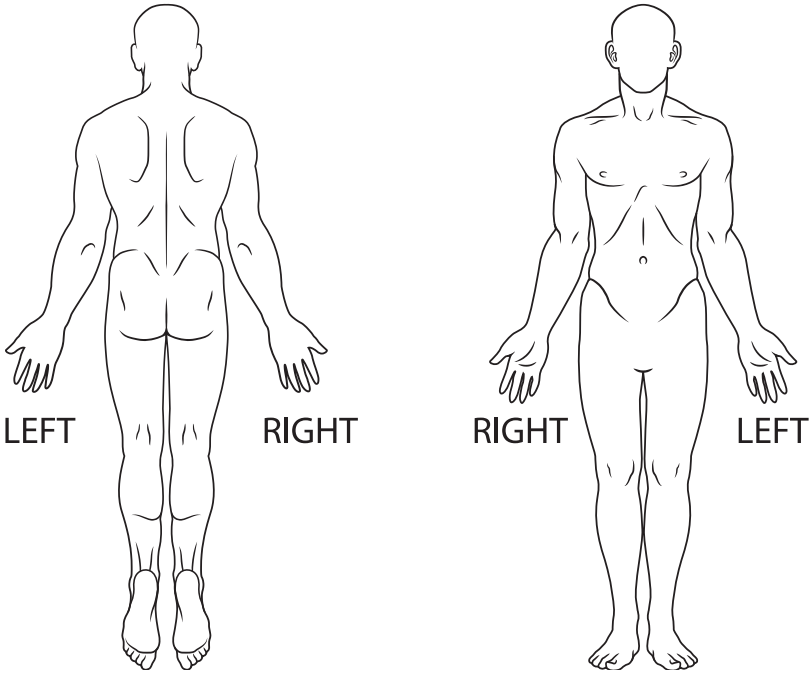
Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMM	— — —	0 0 0 0
M	— —	0 0 0

Pins and Needles	Stabbing	Other
□ □ □ □ □ □	/////	x x x x
□ □ □ □	////	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>LOWEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>HIGEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

What goals do you wish to achieve in physical therapy? _____

_____

_____

_____

_____

Dry Needling Consent Form

Functional Dry Needling/IMS involves placing a small filament needle into the muscle at the trigger point. A trigger point is typically an area where the muscle is tight and tender. The purpose of the needling is to cause a local twitch response to normalize muscle tone. This, in turn, can help increase mobility around a joint and decrease pain. This type of needling is often effective in the treatment of myofascial pain. Functional dry needling is performed by a licensed physical therapist who has received the required training needed to perform this technique. Your therapist may or may not recommend preforming this treatment. If you have any questions or concerns please bring them to your therapist.

Potential risks that are relatively common are bruising and short-term increased pain. Increased point tenderness pain is common but often goes away within a few hours. Complications from Functional Dry Needling are not common but can include: hematoma, nerve irritation, and infection.

Contraindications for needling include: pregnancy, malignant tumors, bleeding disorders, unstable blood pressure, and internal organ disease. Please let your therapist know before treatment if you have any of these, or if you have any known disease or infection that can be transmitted through bodily fluids (HIV, Hepatitis, etc.)

By signing this form, you are agreeing not to hold Act Now Physical Therapy and Eric Deakins DPT for any complications that could arise from the usage of this technique.

I consent to and voluntarily assume the risks of my participation in getting Functional Dry Needling. I will inform Act Now Physical Therapy and my therapist of any concerns I have regarding this procedure as well as any of the contraindications listed above. I understand that no guarantee or assurance has been made as to the results of this technique and that is may not cure my injury or pain.

Signature_____

Printed Name_____

Date_____

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Consent for Treatment

I consent to and authorize my physical therapist and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care providers(s). I acknowledge that no guarantees have been made to me about the results of treatment.

Financial Responsibility

The patient (or patient's guarantor, if a minor) is ultimately responsible for the payment for his/her treatment and care. It is the responsibility of the patient/guarantor to ensure that their ordering provider obtains any necessary prior authorization and/or precertification as required per their insurance company guidelines. If the provider does not obtain the precertification/authorization or it is denied, the patient/guarantor will be financially responsible for the charges billed. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan administrator, or employer representative for resolution. If it is necessary to refer the account to our collection attorneys, the patient agrees to pay the cost of collection including attorney's fees of 25%. If the insurance company issues any refunds or checks to the patient, that check should be turned over to Act Now Physical Therapy and Concussion Management. All expenses not covered by insurance will be the patients' responsibility.

Cancellation Policy

I acknowledge that making physical therapy appointments is a commitment to my health and that it is important to follow the therapist's and physician's frequency and duration prescribed. I realize that my therapist's time is valuable and that my appointment is a held spot that no one else can schedule in; therefore, if I cancel without advanced notice, another patient cannot be seen. As such, I acknowledge that I am responsible for a $25 cancellation fee if I do not provide 24-hour notice. I will provide a credit card to put on file in the event that this charge is incurred.

HIPAA and Release of Information

I understand that Act Now Physical Therapy and Concussion Management may document medical and other information related to my treatment in electronic and other forms and that such information will be used during the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Act Now Physical Therapy's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Act Now Physical Therapy's Notice of Privacy Practices (viewable online at www.actnowpt.com under patient tab) and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information. I understand that the practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

Patient (or Patient's Guardian) Signature _____

Printed Name _____

Date _____

Credit Card #_____ Expiration_____ CVV_____