ELITE Ortho-Therapy & Sports Medicine

PATIENT INFORMATION

NAME____

ADDRESS____

CITY____________________________________STATE_____________ ZIP________________ MARITAL STATUS: M / S /

W BIRTHDATE________________________AGE___________________________ SEX: (M /F) Enrolled in Medicare (Y / N)

PHONE __________________________ Involved in a personal injury or worker's Comp Case (Y / N)

EMPLOYER____ JOB TITLE_________________________________

ADDRESS____

CITY____ STATE__________ZIP_______________________

EMERGENCY CONTACT____ PHONE____________________________________

REFERRING PHYSICIAN____PHONE___________________________________

OTHER REFERRAL SOURCE____

MEDICAL HISTORY QUESTIONNAIRE

Please answer each question fully and to the best of your ability. This information helps us best assess your situation, and get you the care and results you deserve.

Please describe the main reason for your visit ____ ___

____

____

____

When did you first experience this problem? ____

How did this problem first begin?

____

____

PATIENT/ GUARDIAN SIGNATURE:______________________________________ DATE:_____________________________

How often do you experience this problem:

1-2/week___ 3-4/week___ 5-6/week ____Daily

Please grade the intensity of the problem with 10 being the worst,

0 being no pain whatsoever

At Best: 1 2 3 4 5 6 7 8 9 10 Today 1 2 3 4 5 6 7 8 9 10

At Worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (burning, stabbing, aching, sharp, etc.)?:

____

Please describe the location of the pain:

____

Does the problem cause pain to travel to any other area? Yes No

If yes,
explain____

Is this problem getting: ____worse? ____better? ____staying the same?

Have you had similar injuries before? ____

Does it interfere with your normal living and working? ____ Yes ____ No

In what way? ____

What seems to aggravate this problem? ____

What have you tried to relieve this problem (ice, massage, over-the-counter remedies, surgery, physical therapy)?
____

Have you seen other doctors? Yes No Who?_________________________

What treatment was given?
____

How effective was the care? ____

PATIENT/ GUARDIAN SIGNATURE:____ DATE:__________________________

List any other conditions that you are interested in having corrected. List in order of importance.

1. ____

2. ____

What activities are you unable to perform or induce pain upon performance.(sitting, running, bending etc.)____

____

What are your treatment goals?

____

LIFESTYLE & SOCIAL HISTORY

Job Description: ____

Work Schedule: ____

Workout Schedule: ____

Recreational Activities: ____

Do you smoke cigarettes? Yes No If yes, how much? ______________________

Do you drink alcohol? Yes No If yes, how much? __________________________

Do you drink coffee? Yes No If yes, how much? ___________________________

How regularly do you exercise? _______x/week _____Occasionally ______Never

What kind of exercise do you do? ____

How many hours of sleep do you get on average?

____

On a scale of 1-10, please rate your stress level (1=none, 10=extreme)

Occupational ____________ Personal _____________

MEDICAL HISTORY

Surgeries:

Date Type and Reason for Surgery

____________ ____

____________ ____ ____________

____

Previous Injuries, Trauma, or Motor Vehicle Accidents:

Date Type and Description

____________ ____

____________ ____

____________ ____

Prescription Drugs:

Name of drug Dosage and reason for medication

____________ ____

____________ ____

____________ ____

____________ ____

Nutritional Supplements:

Name of supplement Does, frequency, and reason for supplement

______________ ____

______________ ____

______________ ____

Allergies:

______________ ____

______________ ____

______________ ____

INFORMED CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. There are some risks or complications that may be associated with treatment, in particular you should note:

a. Ortho-Therapy Manual Therapy and Soft Tissue Mobilization: local discomfort, skin reddening, superficial tissue bruising, release of emboli (rare), post treatment soreness, or increase in pain which can last up to 72 hours or notice that symptoms shift to different areas which is rarely a concern

b. Active Therapeutic Exercises: aggravation of a present condition, blood pressure changes, increase in heart rate;

c. Therapeutic Taping and cryotherapy (ice therapy): skin reactions including, but not limited to itching, allergic reactions, hyperpigmentation, and blistering

d. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

e. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my health-care provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment. I do no expect my health-care provider to be able to anticipate all risks and complications. I choose to rely on the provider's professional and clinical judgment during the course of care which the provider feels are in my best interests at the time, based upon the facts then known.

I consent to the treatments offered or recommended to me by my health-care provider, including osseous and soft tissue manipulation. I have read and fully understand the above statements and I intend this consent to apply to all my present and future care with Elite Ortho-Therapy personnel.

TO BE COMPLETED BY PATIENT:

____

Patient signature (or Legal Guardian) **Patient Name:**____________________

(Please Print)

Date Signed:________________________

Patient Date of Birth:_____________

Notice of Privacy Practices

I understand that the providers of Elite Ortho-Therapy and Sports Medicine may refuse to diagnose or treat me if I do not consent to the use or disclosure of my protected health information for the above stated purposes.

The "Notice of Privacy Practices" is a document that describes the type of uses and disclosures of your protected health information that will occur in your treatment, payment of your bills, and in the performance of healthcare operations of the clinic.

In signing this document, I acknowledge that I have been given a copy of the Notice of Privacy Practices and have been informed that I have the right to review the Notice prior to signing this document.

I understand that I have the right to request that the clinic restrict how my protected health information is used and/or disclosed to carry out treatment, payment and/or health-care operations. I understand that the clinic is not required to agree to any restrictions that I have requested, but if the clinic agrees to a requested restriction, then the restriction is binding on the clinic.

I understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that such revocation shall not apply to actions already taken by the clinic based on this consent document.

Elite Ortho-Therapy and Sports Medicine reserves the right to change the privacy practices described in the "Notice of Privacy Practices" document. Any revisions to the Notice will be made available to you at your request and will be posted in the reception area.

I have read and understand the foregoing notice and my questions have been answered to my full satisfaction.

____

Patient signature (or Legal Guardian)

Patient Name:_____________________

(Please Print)

Date Signed:_______________________

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize Dr. ____________________, and whomever he or she may designate as assistants, to render

diagnostic tests, apply manual therapy, and conduct post treatment rehabilitation exercises as deemed necessary to my child.

_____________________________________, ____.

(Indicate relationship to minor child) ***(Name of Minor Child)***

As of this date, I have the legal right to select and authorize healthcare services for the minor as named above.

______________________________ **Parent/**

Legal Guardian Signature

Parent/Guardian Name:_____________________

(Please Print)

Date Signed:_______________________

Non-Physician Disclaimer

I understand that Cristal Archuleta and Pat Pacheco, are Licensed Massage Therapists and do not portray themselves to be physicians.

I understand that the massage therapist is providing massage therapy services within their scope of practice.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me.

It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name ______________________ Signature of Patient/Guardian ______________________

Informed Consent to Treat with Meridian Trigger Point Therapy

I, ___________________________, consent to be treated with Meridian Therapy/Dry Needle Trigger Point Therapy by a licensed Elite OSM practitioner. The therapist uses only sterile, disposable needles and maintains a clean and safe environment. This treatment is generally safe, but I understand there may be some side effects or risks from treatment.

I understand there is a chance of bruising or swelling from the needles. I understand that there is a chance of light headedness, weakness, tingling, nausea, or vomiting during treatment and, in very rare cases, internal organ puncture, infection, or temporary nerve damage where needles were placed. I understand I may be sore after my treatment with Meridian Therapy/Dry Needle Trigger Point Therapy and that following self-care instructions from the therapist is essential for continuing the healing effect post treatment.

I have a right to refuse any part of my treatment and can discuss the risks and benefits of Meridian Therapy/Dry Needle Trigger Point Therapy further with the practitioner before I sign this form or at any time thereafter.

I understand that Meridian Therapy/Dry Needle Trigger Point Therapy is not covered by insurance and that I am solely responsible for the costs of this treatment.

____ ________________________________

Please Print Patient Name Date of Birth

____ ________________________________

Patient or Responsible Party Signature Relationship to Patient

____

Date