ZENSHIN WELLNESS PHYSICAL THERAPY INTAKE

PATIENT INFORMATION

Full Name: _____
Email: _____
Address:_____
Phone: _____ DOB: _____ Age:____
Preferred Contact Method: □ E-mail □ Phone □ Text Message

PATIENT MEDICAL HISTORY

Have you been diagnosed with any of the following conditions? (check all that apply)

□ Allergies
□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Bladder/Bowel problems
□ Cancer
□ Cardiac disease/conditions
□ Pacemaker/defibrillator
□ Circulation problems
□ Currently pregnant
□ Depression
□ Diabetes
□ Dizziness/vertigo
□ Emphysema/Bronchitis
□ Fibromyalgia/Chronic fatigue
□ Fractures
□ Gastrointestinal problems
□ Gallbladder/Kidney problems
□ Headache/Migraines
□ Hepatitis
□ Hernia
□ High blood pressure
□ Incontinence
□ Metal implants
□ Multiple sclerosis
□ Neurological disorder
□ Numbness/tingling
□ Osteoporosis/Osteopenia
□ Pain syndrome/CRPS
□ Parkinson's
□ Seizures
□ Speech problems
□ Strokes
□ Thyroid problems
□ Vision problems

Are you on blood thinners □ Yes □ No
Are you pregnant □ Yes □ No
Reason for visit:_____

_____

_____

Have you been treated for this condition before? □ Yes □ No
Was it helpful? □ Yes □ No

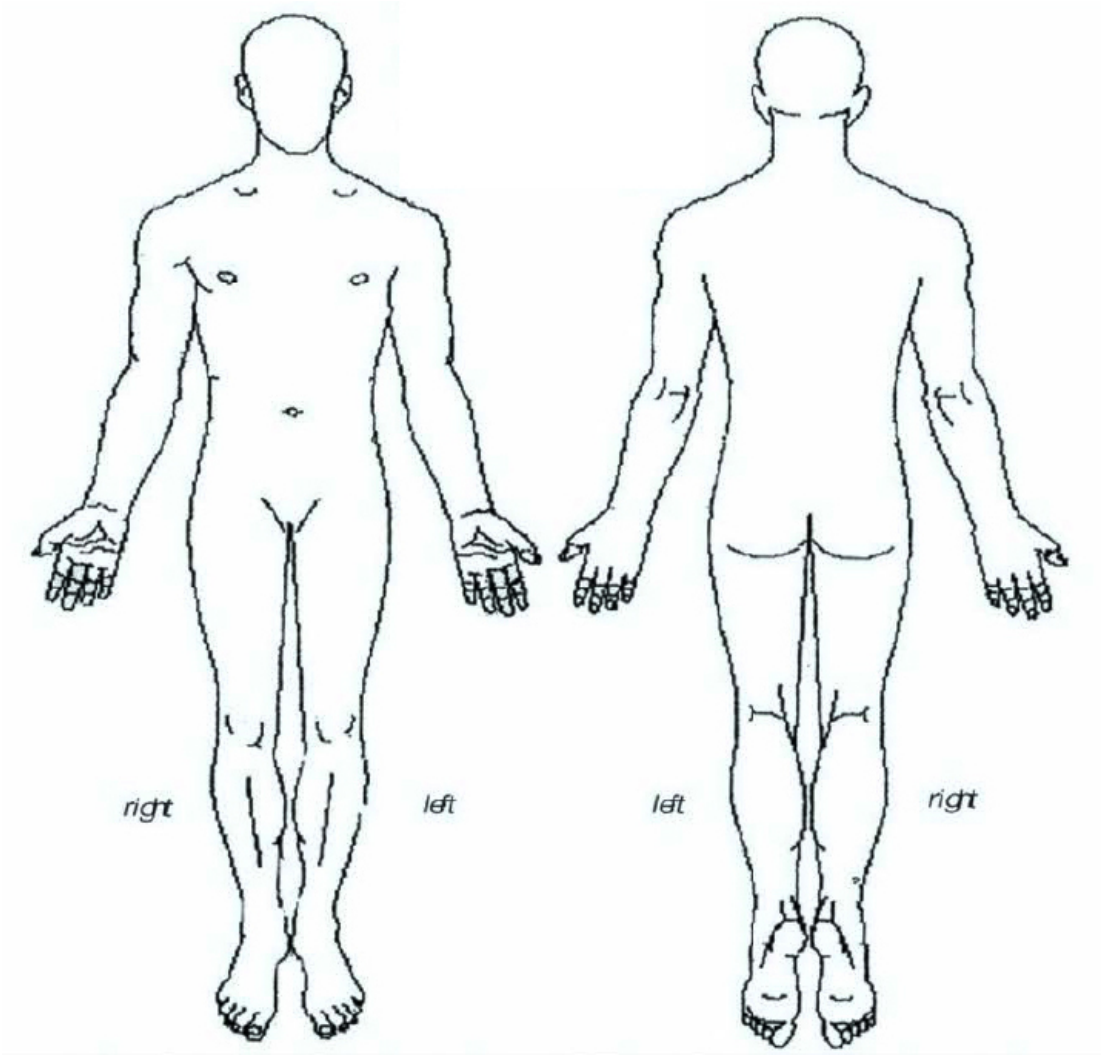
PAIN

Please rate your pain: (0=None, 5=Moderate, 10=Severe)

At present: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
At best: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
At worst: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Please mark the areas on the body where you feel pain:

Pain ^^^^^	Numbness 00000	Pins & Needle ◇◇◇◇
Radiating Pain /////	Burning xxxxx	



WHEN IS THE PAIN WORSE?

□ Morning
□ Afternoon
□ Evening
□ No consistent time of day

LIST ACTIVITIES OR POSITIONS THAT IMPROVE YOUR PAIN _____

_____

CANCELLATION AND NO SHOW POLICY

Zenshin Wellness strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. I realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notification allows me to offer your time to another patient who is in need of services. Therefore, Zenshin Wellness has implemented a 24-hour cancellation policy. Please provide 24-hours' notice to change or cancel an appointment. Patients who do not arrive for a scheduled appointment or do not provide 24- hours' notice to change an appointment may be charged a cancellation fee of $60.

I HAVE READ THE CANCELLATION AND NO-SHOW POLICY:

PATIENT SIGNATURE:_____ DATE:_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, hereby agree and give my consent for Dr. Heather Horii to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (Patient initial)

FOR MINORS ONLY: CONSENT FOR CARE: As parent and/or legal guardian, I authorize the physical therapist named in this document to treat the minor patient named in the attached forms while I am not present. _____ (Parent/Guardian initial)

RISKS: The most serious risk with functional dry needling (FDN) is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should be a major concern. Other risks include bruising which is not of concern, infection, and/or nerve injury.

By signing below, I agree that all of the above information is correct, and that I authorize Dr. Heather Horii to provide me with physical therapy services, including but not limited to the use of FDN and/or cold laser therapy.

Signature: _____ Date: _____

Print Name: _____