HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name	☐ M ☐ F	**DOB:**
Cell Phone / Email address:		
Personal Physician name:		**Personal Physician phone:**
Emergency contact name		**Emergency contact phone:**
Date of last physical exam:		

PERSONAL HEALTH HISTORY

Childhood illness:	☐Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever ☐Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia:
	☐ Hepatitis:	☐ Chickenpox:
	☐ Influenza:	☐ MMR *Measles, Mumps, Rubella:*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital or Physician

Other hospitalizations

Year	Reason	Hospital or Physician

Have you ever had a blood transfusion?	☐ Yes	☐ No
Have you ever tested positive for COVID-19	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements, topicals and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

(PLEASE CHECK BOX IF YOU HAVE HAD ISSUES RELATED TO THE FOLLOW)		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Notes:

AUTHORIZATION FOR PERFORMANCE MEDICINE SERVICES AND CONSENT FOR TREATMENT

I, _____
(name - please print)

I hereby give consent to the Athletic Training staff and/or other performance medicine clinical staff to provide Athletic Training or performance medicine services.
Performance medicine services include but are not limited to: administering first aid for performance related injuries, providing initial treatment and management of acute injuries, and assessing performance related injuries at the request of the artists/athlete, the artists / athlete's coach, organization administration, or the artists/ athlete's parent/guardian. The Athletic trainer and/or performance medicine clinical staff will perform only those procedures that are within their professional training, credential limitations and scope of professional practice to prevent, care for and rehabilitate performance related injuries. It is also my understanding that as part of the performance medicine and Athletic Training staff, the directing physician(s) has the authority to withhold the above artists / athlete from further participation because of an injury or illness.

I understand that there is no charge to me for the above listed Athletic Training / performance medicine services. If I am in need for further treatment by a physician or other medical professional, I understand that I may see the provider of their choice.

In circumstances where I have been removed from participation due to a suspected concussion or head injury, I understand that the I will not be permitted to return to participation until the I have been evaluated by a licensed health care provider and receives written medical clearance/authorization from that provider.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without either my authorization under HIPAA or my consent under FERPA. I hereby authorize the Athletic Training and/or other performance medicine staff to disclose and discuss medical records with coaches, directors or stage management staff and/or other healthcare providers involved in the artists / athletes' medical care.

Signature (by checking this box I confirm that I have signed this document: ☐

Date: _____

Athletic HealthCare

Dry Needling Consent & Information Form

Dry needling involves inserting a tiny monofilament needle in a muscle(s) to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension and will promote healing. This is not traditional Chinese acupuncture but is instead a medical treatment that relies on a medical diagnosis to be effective. Dry needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with dry needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest xray and no further treatment. The symptoms are 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 not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My Athletic Trainer has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

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 (ex: Aspirin, blood thinners)?	☐	Yes	☐	No
4.	Are you currently taking antibiotics for an infection?	☐	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

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.
You have the right to withdraw consent for this procedure at any time before it is performed.

Patient Name or Authorized Representative Name: ☐ Date:
Signature (by checking this box I confirm that I have signed this document:

Athletic Trainers Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof and has consented to its performance. NAME of AT:

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Athletic HealthCare to disclose my health care information and to discuss my health care needs to those that I designate. These individuals are considered my emergency contacts. Without authorization, no information may be shared.

I authorize Athletic HealthCare (AHC) to disclose my personal health information to the following people:

Name:_____ Relationship: ☐ _____ Phone: (☐) ☐ _____

CONSENT TO TREATMENT

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for and understand that no guarantee or assurance has been made as to the results for which may be obtained.

Signature (by checking this box I confirm that I have signed this document: ☐

PHOTO

I hereby grant authorization for a copy of my photo identification to be included in my confidential record as well as additional protection against theft of my medical identity. I further grant authorization for photo documentation of any injury or procedure that AHC deems medically necessary to include in my confidential record.

Signature (by checking this box I confirm that I have signed this document: ☐

NOTICE OF PRIVACY PRACTICES

I received a copy of the Athletic HealthCare “Notice of Privacy Practices” today and agree with these privacy policies.

Signature (by checking this box I confirm that I have signed this document: ☐

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize Athletic HealthCare (AHC), to release any medical information required during the course of examination and treatment to my insurance company and I permit payment to AHC from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for additional services incurred after self/patient has been charged for the visit, such as medical supplies, etc. I agree to pay my bill in full for services rendered by Athletic HealthCare (AHC) providers.

Signature (by checking this box I confirm that I have signed this document: ☐