# Welcome to Conte Sport Performance Therapy!

Please fill out this form completely. Thank you!

## Patient Information

Patient Name: _____

Date: _____

Address: _____

City/State/Zip: _____

Phone: _____

Email Address: _____

Age: _____

Date of Birth: _____

Referring Physician: _____

Name of Insurance Company: _____

*If using insurance, please contact your insurance provider to confirm the benefits of your plan. **Also, please send a picture of the front and back of your insurance card to info@conteperformance.com**

## Emergency Contact Information

Name: _____

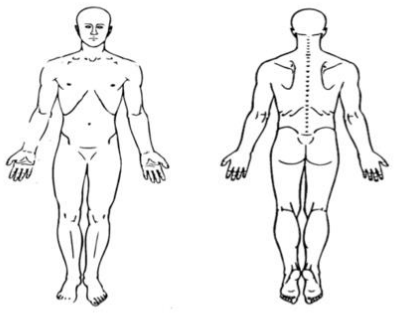
Relation: _____

Phone: _____

## Pain/Symptoms

_____
Pain Level
(0-10)

*Please indicate any areas of pain or discomfort on the diagram below (if applicable):*



Describe your pain: ☐ Dull ☐ Sharp ☐ Shooting
☐ Burning ☐ Stabbing ☐ Other: _____

## Health History

### How did the pain start?

☐ Suddenly ☐ Gradually ☐ Lifting ☐ No apparent reason

☐ Pulling ☐ Injured at work ☐ Bending ☐ Other

### What activities make the pain worse?

☐ Exercise (During) ☐ Exercise (After) ☐ Sitting ☐ Walking

☐ Bending Forward ☐ Bending Backwards ☐ Coughing ☐ Sneezing

### What reduces the pain?

☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Pain Pills
☐ Anti-Inflammatories ☐ Injection for Pain ☐ Muscle Relaxants
☐ Nothing ☐ Other

### How long have you had this pain?

_____ Years, _____ Months, _____ Weeks

### Have you had any diagnostic testing?

☐ X-Rays Date: _____
☐ CT Scan Date: _____
☐ EMG/NVC Date: _____
☐ MRI Date: _____
☐ Arthrogram Date: _____
☐ Injections Date: _____

### Have you been hospitalized for your problem?

☐ Yes Date: _____
☐ No

### Have you had surgery for your problem?

☐ Yes Date: _____
☐ No

### Have you had any other surgery performed?

☐ Yes Date: _____
☐ No

### List any medications are you currently taking:

_____

_____

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## Health History (Continued)

Yes/No

☐ ☐ Allergies

☐ ☐ Diabetes

☐ ☐ High Blood Pressure

☐ ☐ Heart Disease

☐ ☐ Stroke (CVA)

☐ ☐ Cancer or Tumors

☐ ☐ Lung Problems

☐ ☐ Arthritis-joint Difficulties

☐ ☐ (Ir)regular Headaches

☐ ☐ Dizziness/Blackouts

☐ ☐ Seizures/Nerve Disorders

☐ ☐ Visual Problems

☐ ☐ Menstrual Problems

☐ ☐ Immunity Disorders

☐ ☐ Gout

☐ ☐ Are you pregnant?

☐ ☐ Joint Replacement

☐ ☐ Night Sleep Disturbance

☐ ☐ Change in Bowel/Bladder Habits

☐ ☐ Change in Stool Color or Rectal Bleeding

☐ ☐ Increased Thirst or Hunger

☐ ☐ Frequent Urination

☐ ☐ Indigestion or Heartburn

☐ ☐ Nausea or Vomiting

☐ ☐ Changes in Memory

☐ ☐ Unusual Fatigue/Weakness

☐ ☐ Fever or Chills

☐ ☐ Frequent or Easy Bruising/Bleeding

☐ ☐ Frequent Cramping

☐ ☐ Pain within past 24 hours?

☐ ☐ Do you awaken from pain?

☐ ☐ Do you smoke? _____#/Day

☐ ☐ Do you drink? _____#/Day

☐ ☐ Other: _____

## Patient HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out: a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), b) Obtaining payment from third party payers (insurance company), or c) Daily healthcare operations of the practice treating me. I have also been informed and given the right to review and secure a copy of my documents which contain a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations. You are not required to agree to these requested restrictions. I understand that I may revoke this consent, in writing, at any time. Any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Full Name: _____

Signature: _____

Parent/Guardian Signature (If patient is under the age of 18):

_____

Relationship to Patient (If patient is under the age of 18):

_____

## Financial Policy and Payments

**Weekly packages will be charged on the first day of attendance during the respective week. CSPT accepts payments through Cash, Check, Credit, PayPal, Zelle, or Venmo. Payments should be paid on Monday or the patient's first day of attendance. Attendance is the patient's responsibility. No shows and/or cancellations will not be refunded.**

**Patients that decide to use insurance are encouraged to contact their insurance company in order to fully understand benefits and coverage of their respective plan**. Insurance patients must pay the full amount that the insurance company charges.

Patient accounts carrying a balance longer than 30 days are subject to a minimum monthly payment of $75 or 25% of the outstanding balance due, whichever is larger. There is a $50 service fee for all returned checks. Past due accounts are subject to collection proceedings. All fees including but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.

Patient/Responsible Party Signature:

_____ Date: _____

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## Dry Needling Consent and Information Form

Dry needling is a form of therapy in which fine needles are inserted into the myofascial trigger points, tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of pain and dysfunction in the musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low back pain.

Drowsiness, tiredness, or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, that is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe, however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The sign and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs had been reported in the medical literature following needling; however, these are extremely rare events (1 in 20,000).

| **Is there anything your practitioner needs to know?** | **Yes** | **No** |
|---|---|---|
| Have you ever fainted or experienced a seizure? | ☐ | ☐ |
| Do you have a pacemaker or any other electrical implant? | ☐ | ☐ |
| Are you currently taking anticoagulants (blood thinners e.g. aspirin, warfarin, Coumadin)? | ☐ | ☐ |
| Are you currently taking antibiotics for an infection? | ☐ | ☐ |
| Do you have a damaged heart valve, metal prosthesis, or other risk of infection? | ☐ | ☐ |
| Are you pregnant or actively trying for a pregnancy? | ☐ | ☐ |
| Do you suffer from metal allergies? | ☐ | ☐ |
| Are you a diabetic or do you suffer from impaired wound healing? | ☐ | ☐ |
| Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? | ☐ | ☐ |
| Have you eaten in the last two hours? | ☐ | ☐ |

*Single-use, disposable needles are used in the clinic.*

**Statement of Consent**

I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

Print Full Name: _____

Signature: _____

Parent/Guardian Signature (If patient is under the age of 18):

_____

Relationship to Patient (If patient is under the age of 18):

_____

## Media Consent and Release

I hereby give unconditional and irrevocable permission and authority for Conte Sport Performance Therapy LLC to make audio, video, and still recordings of myself (or minor if signer is under the age of 18, such person being referred to herein as "Subject") and to use the Subject's image, video, name and/or description in any and all advertising, social media usage, marketing and/or promotional campaigns related to Conte Sport Performance LLC. I also hereby release Conte Sport Performance LLC from any liability resulting from the reproduction or distribution of advertising, social media usage, marketing and/or promotional materials using the Subjects image, video, audio, name and/or description. This consent and release are given without any promise of compensation or reimbursement.

Print Full Name: _____

Signature: _____

Parent/Guardian Signature (If patient is under the age of 18):

_____

Relationship to Patient (If patient is under the age of 18):

_____