General Subjective Intake form

Today's Date:_____
Legal Name:_____Gender: (please circle) Male Female
Birth Date:_____Age: (as of today)_____
Home Address:_____
City:_____State:_____Zip Code:_____
Home Phone#:_____Cell Phone#:_____
Does your cell phone accept text messaging? (please circle) YES NO
Email Address:_____
May APTF use your email address to contact you regarding promotional/marketing offers, for other service related information, or for scheduling purposes? (Includes affiliates) YES NO

Occupation:_____
Emergency Contact:_____Phone #:_____Relation:_____

Insurance Company:_____
Referring Physician:_____Office Name/Number_____
How did you hear about us (word of mouth, Doctor, ect): _____

Do you have a current diagnosis from an M.D.? Yes No
If Yes, please list:_____

General Medical Info: (circle any conditions that apply to you, Past or Present)

Osteoarthritis	Rheumatoid Arthritis	Liver disease	Kidney disease
Osteoporosis	High blood pressure	Lung disease	Irritable bowel
Heart Attack	Diabetes	Cancer	Broken bones
Heart disease	Fibromyalgia	Car Accident	Change in appetite
Stroke	Hospitalization	Severe injury	Night Pain
Shortness of breath	Fever/Chills/Sweats	Depression	Pregnant

Have you had a change in bowel or bladder function?_____
Do you have any recent illnesses or conditions not listed above?_____
_____
Do you smoke? If yes, how frequent?_____
Do you have any allergies? If yes, please list:_____

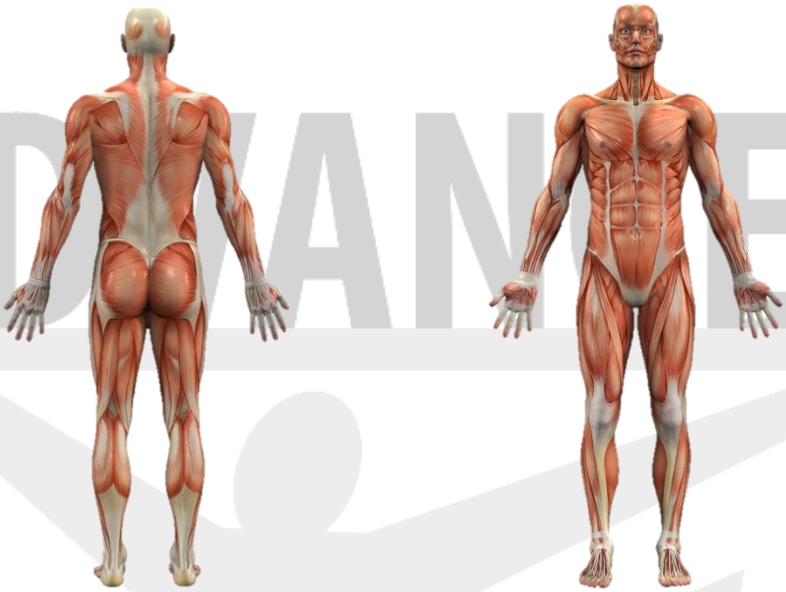
Have you experienced any of the following: (circle any that apply, Past or Present)
Dizziness Nausea Vertigo Headaches
Double vision, Difficulty Swallowing, Difficulty speaking, Fainting, Gait disturbance
Dry/Itchy eyes, Ringing in ears, Pain in the Face/Head/Eye/Tooth/Ear/TMJ
Weakness Loss of sensation Numbness Tingling
Changes in: Smell, Vision, Taste, Hearing, Facial expression, Balance, Swallowing

Please list ALL Surgeries (internal and orthopedic) (include dates if possible, attach separate sheet if needed):_____
Please list or provide a copy of ALL medications, including Dose – (you may attach a separate sheet if needed):_____
_____

Pain/Symptom Intake

Date of when present pain/injury started?:_____
How did it start? (sudden, injury, over time, ect):_____
Are current symptoms getting: (please circle one) Better, Worse, Staying the same

Please circle affected Body Part



Please describe the pain: (achy, dull, sharp, ect)_____

Please rate the pain that you circled (1 is low, 10 is high): 1 2 3 4 5 6 7 8 9 10

Is the Pain constant or intermittent?_____

What can you do to make symptoms worse?:_____
_____

What can you do to make symptoms better?:_____
_____

Does the pain affect your sleep? If so, how?_____

Please circle the following statement that best fits your current symptoms/pain.

- Pain/stiffness is worse in the AM hours but gets better as the day goes on.
- Pain/ache increases as the day goes on.
- Pain is present at rest and is generally worse at the beginning of an activity.
- Pain is not affected by activity or rest.
- Pain occurs at night and is not quickly resolved by changing position.
- Pain occurs during or immediately after eating.

Circle approximate perceived % of limitation of recreational and daily activities: 10%, 20%, 30%, 50%, other:_____

List any Medical Interventions received for current condition (injections, massage, chiropractic, ect):_____
_____

List any Imaging studies performed for current condition (X-rays, CT scan, MRI, ect)_____

Have you had PT or Chiropractic in the past for current condition or for other issues? (if yes, when and for what?)_____

What are your Goals for Physical Therapy?_____
_____

Do you want a note of communication for your M.D.? **Yes** **NO**
If yes, APTF will provide a note you can give to your provider.

Trigger Point Dry Needling (TDN) Consent Form

Trigger point Dry Needling involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms.

TDN is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risks of the procedure:

Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only 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 lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely. Please consult with your practitioner if you have any questions regarding the treatment above.

Please answer the Following:

Do you have any known disease or infection that can be transmitted through bodily Fluids?	**Yes**	**NO**
Do you have an infection? (Respiratory, or other)	**Yes**	**NO**
Do you have an auto-immune disease? (MS, RA, ect)	**Yes**	**NO**
Do you have any reason to believe you have a compromised immune system?	**Yes**	**NO**
Do you have a bleeding disorder?	**Yes**	**NO**
Do you take any blood thinning medication? (Coumadin, or other)	**Yes**	**NO**
Are you pregnant?	**Yes**	**NO**
Do you have any implants? (pacemaker, spinal cord stimulator, silicone, ect)	**Yes**	**NO**
Do you have Cancer or are you taking any Cancer medications?	**Yes**	**NO**
Do you have any joint replacements?	**Yes**	**NO**
Are you under 18 years of age?	**Yes**	**NO**

If you marked yes any of the above, please discuss with your practitioner.

_____

Please print your name.

_____ _____

Signature Date

By signing above, I acknowledge giving consent for dry needle treatment.

What to expect after receiving Trigger Point Dry Needling (TDN)

How will I feel after a session of TDN?

- You may feel sore immediately after treatment in the area of the body you were treated, this is normal but does not always occur. It can also take a few hours or the next day before you feel soreness. The soreness may vary depending on the area of the body that was treated and varies from person to person. Typically the soreness feels like post gym workout muscle soreness or the soreness you may feel after a deep muscular massage. Soreness typically lasts 24-48 hours. If soreness continues beyond this please contact your treating therapist.
- It is not uncommon to have bruising after treatment; some areas are more likely than others. Some common areas are shoulders, base of neck, head and face, arms and legs. Large bruising rarely occurs, but can. Use ice to help decrease the bruising and if you feel concern please call your treating therapist.
- It is not uncommon to feel tired, nauseous, emotional, giggly or "loopy", and/or somewhat "out of it" after treatment. This is a normal response that can last up to an hour or two after treatment. If this lasts beyond a day contact your treating therapist as a precaution.
- There are times when treatment may actually make your typical symptoms worse. This is normal. If this continues past the 24 hour – 48 hour window, keep note of it, as this is helpful information and your treating therapist will then adjust your treatment plan based on your report if needed. This does not mean TDN cannot help your condition.

What should I do after treatment, what can I do?

- It is highly recommended that you increase your water intake for the next 24 hours after treatment to help avoid soreness.
- It is recommended that you soak in a hot bath or hot tub to help avoid post treatment soreness.
- After treatment you may do the following based on your comfort level, if it hurts or exacerbates your symptoms then stop;
  - Work out and/or stretch
  - Massage the area
  - Use a heating pad
  - Take Tylenol, Ibuoprofen/Motrin, Aspirin for the soreness. All are okay as long as you know your system can handle them.

What should I Avoid?

- Avoid ice unless you are icing a bruise, heat is better for muscle soreness.
- Avoid drinking alcohol since this can dehydrate you, but if you do so, it is recommended you do not do so excessively.

If you are feeling light headed, having difficulty breathing, having chest pain or any other concerning symptoms after treatment CALL APTF immediately. If you are unable to get a hold of APTF, call your physician

Advanced Physical Therapy and Fitness
Notice of Privacy Practices, Updated 2014

Your Information, Your rights, and Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of APTF's responsibilities to help you.

1. **Access to an electronic or paper copy of your medical record. Once requested, this information will usually be generated within 30 days and you may be charged a reasonable cost based fee.**
2. **Correct your medical record. If your medical record with APTF is incorrect or incomplete you may ask for it to be corrected. APTF may say 'no' to this request but will provide a written reason why within 60 days.**
3. **Request confidential communications. You may specify how APTF contacts you. (for example, home or office phone, or send mail to a different address). APTF will say 'yes' to all reasonable requests.**
4. **Ask us to limit what we use or share.** You can ask APTF to **not** to use or share certain health information for treatment, payment, or our operations**. APTF is** not required to agree to your request, and may say 'no' if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask APTF to not share that information for the purpose of payment with your health insurer. APTF will say 'yes' unless a law requires the information to be shared.
5. **Get a list of those with whom information has been shared.** You can ask for a list (accounting) of the times APTF has shared your health information for six years prior to the date you ask, who we shared it with, and why. APTF will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). One accounting a year will be provided for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. APTF will provide you with a paper copy promptly.
7. **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. APTF will make sure the person has this authority and can act for you before we take any action.
8. **File a complaint if you feel your rights are violated.** You can complain if you feel APTF has violated your rights by contacting APTF using the information on the back page. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** APTF will not retaliate against you for filing a complaint.

Your Choice: For certain health information, you can tell APTF your choices about what gets shared. If you have a clear preference for how APTF shares your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. Share your personal health information with your family, close friends, or others involved in your care.
2. Share information in a disaster relief situation.
3. **In these cases APTF *never* share your information unless you give us written permission:** Marketing purposes, and Sale of your information.
4. **In the case of fundraising:** APTF may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: How does APTF typically use or share your health information?

We typically use or share your health information in the following ways.

1. We can use your health information and share it with other professionals who are treating you.
2. We can use and share your health information to **run our practice**, improve your care, and contact you when necessary.
3. We can use and share your health information to **bill** and get payment from health plans or other entities.

How else can APTF use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues: APTF can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- We can use or share your information for health research.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests: APTF can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

APTF is required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

APTF can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

If you have any questions about this notice, see contact information below:

Thomas Cleveland

Advanced Physical Therapy and Fitness

1951 Harvard Place

Loveland, CO 80538

970-301-3149

www.AdvancedPTandFitness.com

EFFECTIVE DATE: 4-13-2003

Advanced Physical Therapy and Fitness Rates and Packages
Effective 02-01-20

Cash Rates:

Consultation	**FREE** (30 minutes)	
Initial Evaluation	$100 (1 hour)	
Follow-up Visit	$50 (30 Minutes)	$75 (1 Hour)

*Veterans and Active Duty Military - 10% off
*WOW Employees and Family - 10% off
*WOW Members currently working with WOW personal training staff - 10% off

Packages:

	30 Minute Session	1 Hour Session
5 Pack (5% off)	$ 238	$ 356
10 Pack (10% off)	$ 450	$ 675
20 Pack (20% off)	$ 800	$1,200

**Family and Friends may share visits in all package purchases.

Taping:

Kinesiology Tape	Rock Tape Standard Roll 2" x 16.4'	$20
Stability Tape	Leukotape P + Cover Roll	$20

Application of Tape:

Clinic Tape	$20 - one body part ($5 for each additional body part)
Your Tape	$15 – one body part ($5 for each additional body part

Call to Schedule your appointment today!

Advanced Physical Therapy and Fitness
Thomas Cleveland, PT, DPT,
ACSM HFS™
www.AdvancedPTandFitness.com
TClevelandDPT@gmail.com
970-301-3149

Consent and Statement of Financial Policy

In consideration of treatment by APTF, I the undersigned(s), jointly and severally, understand and agree:

*The preceding information is correct to the best of my knowledge.
*I am responsible for all fees relative to the professional services rendered under this agreement (from the current fee schedule), that this may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present, and future services rendered by APTF to me, my family, or other individuals I may have authorized. I recognize that APTF has a relationship with me, the patient/client, not with the insurance company. I agree that I will pay all charges under this agreement regardless of my insurance coverage. I may terminate my responsibility under this agreement by paying my account in full and giving written notice to APTF.
*I will pay all sums that are due and payable at the time of, or in advance of the service. No oral agreements have been made and this agreement cannot be modified orally. Accepted forms of payment include cash, check, or credit card.
***A 24 hour notice** is required for cancellation or re-scheduling of any scheduled visit. APTF reserves the right to charge a **FULL SESSION FEE** for late cancellation. APTF may also ask for pre-payment of future sessions after multiple late cancellations. Any late cancellation fees that are assessed must be paid IN FULL prior to commencing the remainder of the contracted or scheduled visits. Exceptions apply for late cancellation due to illness and/or emergency situations.
*I agree to pay interest at the rate of 18% annually on all balances over 90 days from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 50% of the outstanding balance.
*Visits will be conducted at APTF's office, unless otherwise arranged.
*APTF may request that the patient/client obtain a medical doctor's clearance prior to starting any rehabilitation program.
*Confidentiality will be strictly enforced between patient/client and therapist.
*Sexual harassment will not be tolerated by either patient/client or therapist.
*If patient/client is under 18 years of age, a legal parent or guardian must sign below, authorizing consent.
*I have fully read, understand, and agree to the contract listed above.
*I hereby consent to receive services from APTF as deemed necessary and advisable by the therapist or as recommended by my physician. I also authorize any physician, hospital, school, referring agency, or other person who has medical records pertaining to me to release them to APTF upon request.
*I have been informed of my rights as a patient and have received APTF's **Privacy Notice** and **Financial Policy**. I have also been given the chance to ask any questions prior to signing.

Patient Signature _____ Date _____

(If Under 18) Parent Signature _____ Date _____