INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

Dry Needling Intake Form

Name:		**Email:**
Address:		
City, State, Zip:	**DOB:**	**Age:**
Home Phone:		**Cell Phone:**
Emergency Contact (Name & Phone):		
Referred by:		**Marital Status:**
Occupation:		
Have you ever had dry needling before?		**With whom and results?**
Reason for today's visit:		
How long have you had this condition?		**Is it getting worse?**
Does it bother your: ☐ **Sleep** ☐ **Work** ☐ **Other (What?)**		
Is this your first time with this condition?		
What seems to make it better?		**What seems to make it worse?**
Other concurrent therapies?		**Do you have surgical/cosmetic implants?** **If yes, where?**

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Dry Needling Consent Form

Dry needling (DN)

DN is a technique that involves the insertion of acupuncture needles (without medication) as a means to promote healing within the body. Dry needling works by changing the way your body senses pain (neurological effects), and by helping the body heal itself. There are additional electrical and chemical changes associated with dry needling therapy which assist in the healing process. It is important to see dry needling may act as just one part of your overall rehabilitative treatment. Treatment techniques are based on concepts of modern medicine and are not to be considered acupuncture. Risk of injury and/or potential complications could result from DN if proper precautions are not observed. If you are being treated in the shoulder, neck, back or chest area, there is an additional risk that involves your lung. If the lung itself is punctured, you may develop a condition called a pneumothorax (air in the space around the lung). This is a rare but serious problem, and you should go directly to a hospital ER department without panicking if it occurs. The symptoms of this event include shortness of breath which gets worse, sudden sharp pain each time you breathe in, a bluish tinge to your lips, and an inability to "catch your breath". In general, there is very little risk associated with this technique if performed properly.

- 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 as well as varies person to person, but typically it feels like you had intense workout at the gym. Soreness typically lasts 24-48 hours. If soreness continues beyond this, please contact your provider.
- It is common to have bruising after treatment; some areas are more likely than others. Some common are shoulder, 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 provider.
- It is common 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 provider as a precaution.
- There are times when treatment may make your actual 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 provider will then adjust your treatment plan based on your report if needed. This does not mean DN cannot help your condition.

Other complications that could result from DN: bleeding, bruising, infection, or nerve injury.

During a DN treatment you may experience temporary:

Pain, sweating, nausea, anxiety, dizziness, pain referral or muscle twitch. After a DN treatment you may experience temporary: muscle soreness, muscle tightness, paresthesia or joint stiffness.

Print Name: _____ Date: _____

Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

INITIAL IF READ ABOVE: _____

TERMS OF ACCEPTANCE

When accepting a new client who is seeking chiropractic, A.M.I.T, pulse, Class IV laser, dry needling, cupping, and/or acupuncture, it is essential for both the client and the doctor to be working towards the same objective. Chiropractic has only one goal to work toward the cause, not the effect. It is only when the client understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental and social well being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or alteration of nerve function and interference of the transmission or nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

INITIAL IF READ ABOVE: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of you records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*
- *You may request super bill, documentary of visits by email.*

I have read and understood your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT (if minor):
SIGNATURE:	DATE:

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