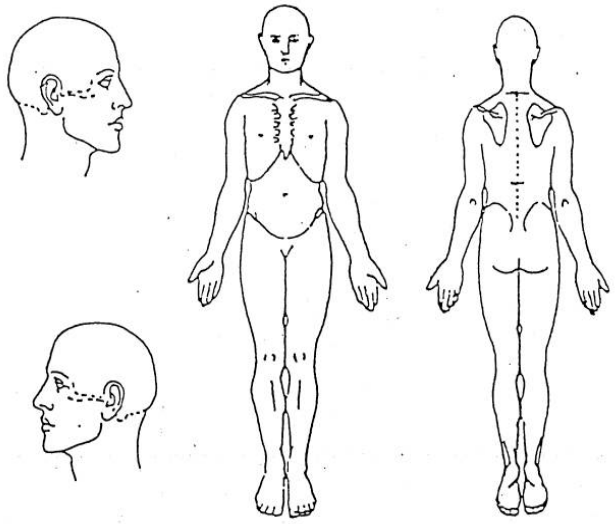
Holt Physical Therapy Dry Needling Questionnaire

Patient Name: _____ Date of Birth:_____ Contact Phone:_____

Referring MD or Primary Care Doctor: _____

Emergency Contact Name, Phone & Relationship to Patient: _____

On the diagram below, please indicate the area or areas where you are currently experiencing pain or other symptoms by marking those areas with an X on the diagram:



Have you ever tried dry needling before? ◯ YES ◯ NO If Yes, where?:_____

How long have you been experiencing these symptoms? _____

Please rate your current pain: 0 1 2 3 4 5 6 7 8 9 10

Are you on any blood thinners? ◯ YES ◯ NO Are you Latex Sensitive? ◯ YES ◯ NO

Are you or could you be pregnant? ◯ YES ◯ NO ◯ UNSURE

Do you have any implants? ◯ YES ◯ NO If yes, where?:_____

Any history of cancer? ◯ YES ◯ NO If yes, type/location:_____

Please report any other relevant past medical history:

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize Dry Needling therapy treatment, which may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Holt Physical Therapy & Performance Training.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: ◯ MOTHER ◯ FATHER ◯ LEGAL GUARDIAN