

# DRY NEEDLING MEDICAL HISTORY

Please answer the following questions in order for your physical therapist to provide effect and safe treatment.

Do you have a pacemaker or any other electrical implants? ☐ **No** ☐ **Yes**

Do you have any cosmetic implants? (Pectoral, Deltoid, Biceps, Chin, Calf, Buttock etc.) ☐ **No** ☐ **Yes**



Do you have any medical implants (knee, hip shoulder replacements etc.)? ☐ **No** ☐ **Yes**



Are you currently taking anticoagulants (Blood thinners e.g., warfarin, Coumadin) ☐ **No** ☐ **Yes?**



Do you have hepatitis B, hepatitis C, HIV, AIDS, Cancer or any other infectious disease or currently taking immunosuppressant medications (i.e. decreasing strength of immune system) ☐ **No** ☐ **Yes**



Do you have a damaged heart valve, metal prosthesis or other risk for infections? ☐ **No** ☐ **Yes**



Are you diabetic or do you suffer from impaired wound healing? ☐ **No** ☐ **Yes**



Are you currently taking antibiotics for an infection? ☐ **No** ☐ **Yes** Do you suffer from Metal allergies? ☐ **No** ☐ **Yes** Have you ever fainted or experienced a seizure? ☐ **No** ☐ **Yes**

Females: Are pregnant or actively trying for a pregnancy? ☐ **No** ☐ **Yes**

# STATEMENT OF CONSENT

By signing below, I give consent to evaluation and treatment(s) utilizing Dry Needling. 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 therapist has also discussed with me the probability of success of this procedure, as well as the probability of side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by trained therapist(s) at Pilates Plus Physical Therapy and Wellness, Inc. I also consent to any measures necessary to correct complications that may result, and agree to notify my therapist(s) immediately of the change in my status regarding complications and/or medical history. I understand that I have a right to withdraw consent for this procedure at any time before it is performed. I understand I also have the right to stop treatment at any time, at which point the therapist(s) at Pilates Plus Physical Therapy and Wellness, Inc. will cease current treatment upon your verbalization. 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.

***DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.***



Patient or Authorized Representative Date Time



Relationship to patient (if other than patient) (Patient name printed)

* Patient was offered copy of consent and refused.
* Patient was given copy of consent.

**Physical Therapist 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.



Physical Therapist Signature Date Time