BOSTON HEALTH & WELLNESS

62 Montvale Ave Suite Z
Stoneham, MA 02180
(617) 843-5320

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Email Address:			
Birth Date: / /	Age:	☐ Male ☐ Female	
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		

Chose Clinic Because/ Referred to Clinic by Dr.: _____ ☐ Insurance Plan ☐ Word of Mouth: _____

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Phone: ( ) -
Regular Dr./PCP	Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:		
Subscriber's Name (If different):		Birth Date: / /
ID. #:	Group/Policy #:	Policy Holder's SSN:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth Date: / /
ID. #:	Group/Policy #	
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto:	☐ Labor & Industries:		
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

IN CASE OF EMERGENCY

Name of Local Relative or Friend:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s). Additionally, I authorize my insurance benefits be paid directly to **Boston Health & Wellness** and authorize said practice to release any information required to process my claim. I understand that I am financially responsible for any remaining balance.

PATIENT /GUARDIAN SIGNATURE DATE

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Patient Name: _____ **Email Address:** _____

PAST MEDICAL HISTORY FORM

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
Other:		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			
	☐ Other			

What types of exercise do you perform? _____

What things cause stress in your life?

List all medications you are currently taking: _____

List all surgeries (including dates): _____

Are you pregnant? ☐ Yes ☐ No What week? _____

Have you had any injuries related to work? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had any auto accidents? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ Yes ☐ No Where:

_____ _____

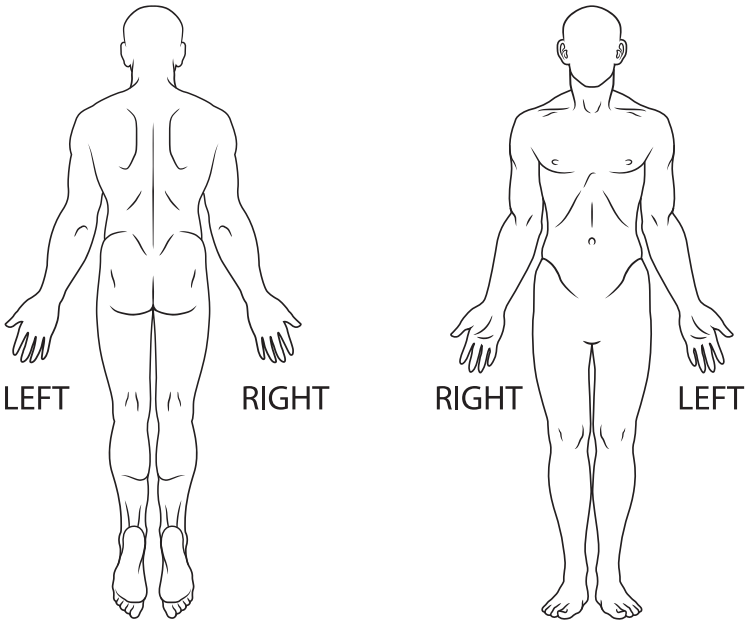
Signature of Patient, Parent, Guardian, Personal Representative Date

Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMM	— — —	0 0 0 0
M	— —	0 0 0
Pins and Needles	**Stabbing**	**Other**
□ □ □ □ □ □	/ / / / /	x x x x
□ □ □ □	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>LOWEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>HIGEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

What goals do you wish to achieve in physical therapy? _____

_____

_____

_____

_____

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DRY NEEDLING CONSENT TO TREAT FORM

Dry needling (DN) is a skilled technique performed by a physical therapist using a single-use, single-insertion, sterile filiform needle, which is used to penetrate the skin or underlying tissue to effect change in body conditions, pain, movement, impairment and disability. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may 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, while rare, may require hospitalization.

Other risks may include bruising, infection or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- **Are you taking blood thinners?** ☐ Yes ☐ No
- **Are you or is there a chance you could be pregnant**? ☐ Yes ☐ No
- **Are you aware of any problems or have any concerns with your immune system?** ☐ Yes ☐ No
- **Do you have any known disease or infection that can be transmitted through bodily fluids?** ☐ Yes ☐ No

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, _____authorize the performance of Dry Needling.

_____ _____
Patient or Authorized Representative Date

_____ _____
Relationship to patient (if other than patient) Date

☐ I was offered a copy of this consent and refused.

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information (PHI) will be used by this practice, known as **Boston Health & Wellness** or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Consent to Use and Disclose Protected Health Information. I give my permission to this practice to use and disclose my health information in accordance with it.

_____
Name of Patient (Print Clearly)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

_____
Emergency Contact

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Cancellation/No-Show Policy

Boston Health & Wellness is committed to your return to function and recognizes the joint effort between patient and physical therapy team as vital to you reaching your goals.

At **Boston Health & Wellness**, helping each and every patient get the results they need is very important. Our schedule tends to be fully booked, making it challenging to accommodate all patient requests. To ensure fairness and efficient use of our appointment slots, we have implemented a 24-hour cancellation policy. If you are unable to attend a scheduled appointment, we kindly ask for 24 hours' notice for the cancellation. By providing sufficient notice, we can assist you in rescheduling the appointment, as our primary objective is achieving the results you need. Please reach out to us at **(617) 843-5320** to initiate the rescheduling process.

Please read the following policy to understand how we can assist you better.

1. Attending your appointment is crucial for your improvement. When you need to cancel, please make sure you have alternative times available so we can reschedule promptly.
2. If you need to cancel an appointment, please be sure to provide us with at least 24 hours' notice. For cancellations made with less than 24 hours' notice, a fee of **$50** will be charged. In the event of a missed appointment without prior notice, a no-show fee of **$75** will apply.
3. While we understand that illness can occur unexpectedly, repeated cancellations without 24 hours' notice due to illness will not be considered a valid excuse for untimely notice.
4. We expect you to arrive on time, properly dressed, and ready to begin your scheduled treatment.
5. If you anticipate running late due to unpredictable traffic, kindly inform us immediately. This will allow us to adjust our schedule accordingly for your late arrival.
6. It's important to note that if you arrive late for your appointment, the time allocated specifically for your care may be affected. We may not be able to provide you with the full treatment as we have reserved the subsequent appointment slot for another patient. Patients consistently arriving late will be asked to change their appointment times.
7. **Please be aware that there is a $50 fee for cancellations made with less than 24 hours' notice, and $75 for no-shows (missed appointments). This fee is your responsibility, as insurance does not cover missed visits. To avoid the fee, please call our office to reschedule any appointments you cannot attend with at least 24 hours' notice.**

Thank you for reviewing this policy. Please sign the attached copy and return it to us. Keep the second copy for your records. We are eager to work with you to achieve your physical therapy goals.

I have read and understood this policy. By signing below, I confirm that I will adhere to it.

_____	_____	_____
Patient Signature	Patient Name	Date