Lamonde Wellness

1445 Haw Creek Circle, #503
Cumming, GA 30041

770-855-5621
855-849-5620
office@lamondewellness.com
LamondeWellness.com

Patient Information

Patient Name _____ Date _____ Date of Birth _____

Phone # _____ E-mail _____

Address _____ City _____ Zip _____

Primary Care Physician _____ Phone # _____ Fax # _____

Who Referred You? _____ Phone # _____ Fax # _____

Emergency Contact _____ Phone # _____

Medical History

Do you have a history of:
(check all that apply)

self			family	self	
❑ Dizziness/Fainting	❑ Childhood Diseases: _____		❑	❑	Diabetes
❑ Shortness of Breath	❑ Headaches		❑	❑	High Blood Pressure
❑ Ankle Swelling	❑ Kidney Disease		❑	❑	Heart Attack
❑ Night Coughing	❑ Lung Disease		❑	❑	Heart Disease
❑ Seizures	❑ STDs: _____		❑	❑	High Blood Cholesterol
❑ Pacemaker/Defibrillator	❑ Other: _____		❑	❑	Smoking
❑ Assistive Device (e.g. cane)	❑ Other: _____		❑	❑	Chest Pain
❑ Falling: _____ (# of falls in last year)	❑ Other: _____		❑	❑	Stroke
❑ Alcohol Use: _____ (# of drinks per week)	❑ Other: _____		❑	❑	Cancer: _____ (type of cancer)
❑ Allergies: _____ (type of allergies)	❑ Other: _____		❑	❑	Osteoporosis
❑ Asthma	❑ Other: _____		❑	❑	Osteoarthritis
			❑	❑	Rheumatoid Arthritis
			❑	❑	Rheumatic Disease

In the past 1 month, have you frequently been bothered by:

❑ feeling down, depressed or hopeless?

❑ having little interest in things or have you lost pleasure in doing things?

Medical History (continued)

In the past 3 months, have you experienced: (check all that apply)

- ❑ diagnosis by a licensed healthcare provider of a chronic musculoskeletal condition? If yes, by who?
  please describe:
- ❑ unexplained change in your health? please describe:
- ❑ explained illness or injury? please describe:
- ❑ unexplained weight change? ❑ night sweats? ❑ changes or difficulty with bowel?
- ❑ fever? ❑ numbness or tingling? ❑ changes or difficulty with bladder?

Do you have difficulty with (check all that apply)

❑ Hearing ❑ Vision ❑ Speech ❑ Communication

Do you regularly exercise? # of days/week # of minutes/session

What is your body weight? Height? Ideal body weight?

Please list any medicine allergies you may have:

Are you allergic to Latex? ❑ yes ❑ no Adhesives? ❑ yes ❑ no

Please list or provide a copy of the medications you are currently taking: (dosages not necessary)

Please list any supplements and/or vitamins you are currently taking:

Please list any surgeries in your past:

Are you or could you be pregnant? (women only) ❑ yes ❑ no

Have you had prostate issues? (men only) ❑ yes ❑ no

Patient Specific Functional Scale

Please list three (3) activities that you are having difficulty performing. Rate your ability next to each activity.

(**0** = unable to perform » **10** = can perform normally)

1.	0	1	2	3	4	5	6	7	8	9	10
2.	0	1	2	3	4	5	6	7	8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10

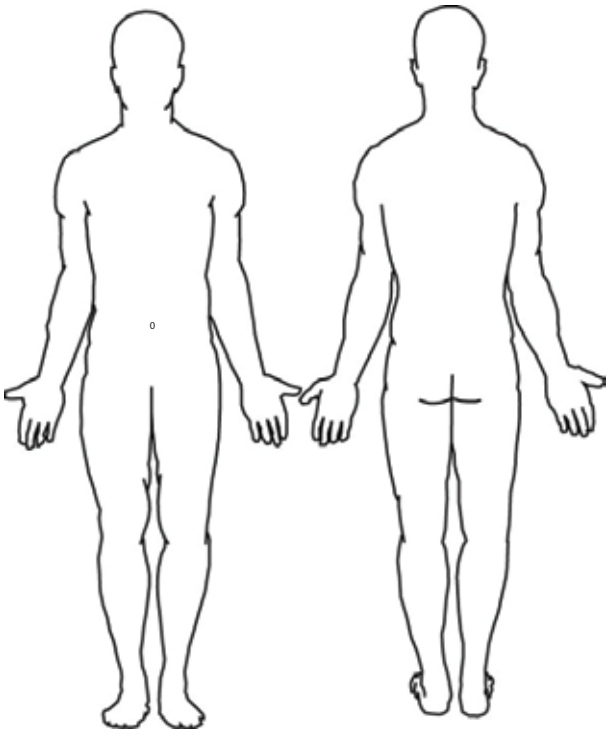
Current living situation?

patient initials

Medical Screen

Please use the diagram to indicate where you feel symptoms right now.
use the following key to indicate the different types of symptoms:

Pins & Needles = oooooo **Stabbing =** //////////
Burning = XXXXXX **Deep Ache =** ZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain on the following line:

0 1 2 3 4 5 6 7 8 9 10

(**0** = none » **10** = worst imaginable. Indicate level for each with B, C, and W)

What makes your pain or symptom worse?

What makes your pain or symptom better?

Are your symptoms:

❑ getting worse ❑ the same ❑ improving

How are you able to sleep at night? (check one)

❑ fine ❑ moderate difficulty ❑ only with medication

Do you have pain at night? ❑ yes ❑ no

When did your problem begin? (date)

Have you been treated for this before? ❑ yes ❑ no

When? How?

Dry Needling Information

What is Dry Needling? Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low back pain.

Is Dry Needling Safe? Drowsiness, tiredness or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less then 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000). Only single-use, disposable needles are used in this clinic.

patient initials

Dry Needling Consent

I have read and understand the dry needling consent form. ❑ Yes ❑ No

Have you ever fainted or experienced a seizure? ❑ Yes ❑ No

Do you have a pacemaker or other electrical implant? ❑ Yes ❑ No

Are you taking anticoagulants (blood-thinners) such as Warfarin or Coumadin? ❑ Yes ❑ No

Are you currently taking antibiotics for an infection? ❑ Yes ❑ No

Do you have a damaged heart valve, metal prostheses or other risk of infection? ❑ Yes ❑ No

Are you pregnant or actively trying for a pregnancy? ❑ Yes ❑ No

Do you suffer from metal allergies? ❑ Yes ❑ No

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

Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? ❑ Yes ❑ No

Have you eaten in the last 2 hours? ❑ Yes ❑ No

General Consent

_____ initials

I hereby consent, voluntarily, to participate in physical therapy, nutrition counseling, personal training, wellness program, or any other treatment within the scope of practice of the provider affiliated with Lamonde Wellness. I understand that I may elect to stop this program at any time. I understand that there is a risk associated with any of the aforementioned treatments of either temporary or permanent injury or death. I have been honest and thorough in my medical history. A physical therapy diagnosis is not a medical diagnosis by a physician and is not based on radiological imaging. Lamonde Wellness does not directly bill third party payers, but will provide a receipt at your request. These services may not be covered by your health plan or insurer.

_____ initials

I have been given an opportunity to review the HIPAA Privacy Policy. I would like a printed copy. ❑ Yes ❑ No

_____ initials

I agree to pay a $25 fee for failing to arrive at a scheduled appointment or if a 24 hour notice is not given prior to cancellation.

_____ initials

Lamonde Wellness uses text messaging, cell phone calls, email and social media to communicate with it's patients and provide educational programming. I give informed consent to the use of the aforementioned methods.

Additional Information

Please use this opportunity to provide us with any additional information.

Patient or Representative Signature

Date