TRITON HEALTHCARE INC.

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Denham Springs, LA 70726

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Patient Information

Please Print
Patient Name:_____ Date of Birth:_____ Age:_____

Responsible Party if Minor:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone#:_____ Work Phone#:_____ Cell Phone#:_____

Social Security#:_____ Email Address:_____

Employer:_____ Address:_____

Occupation:_____ Dr. Referred By:_____

Primary Insurance to Be Billed:_____
Card Holder Name:_____ ID#:_____
Group ID:_____ Customer Service#:_____

Secondary Insurance to Be Billed:_____
Card Holder Name:_____ ID#:_____
Group ID:_____ Customer Service#:_____

Is This Worker's Comp Claim:_____ YES_____NO Injury Date:_____
Was this injury reported:_____YES _____NO Claim#:_____
Contact Person:_____ Telephone#:_____
Car Accident:_____YES_____NO Injury Date:_____
Was this injury reported?_____YES_____NO Claim#:_____
Contact Person:_____ Telephone #:_____
Litigation:_____YES_____NO If YES Attorney's Name:_____
Address:_____

Have you had Physical Therapy Before?_____YES_____NO If so, Where?_____
Have you had any Home Health in the last 60 days for any reason? _____YES_____NO

I hereby give my consent for treatment and authorize Triton Healthcare, Inc. to furnish and receive my information related to this illness or accident to/from my insurance carrier, attorney, or other medical personnel.

Signature:_____ **Date:**_____

Patient Information:

Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

Are you on a work restriction from your doctor? Y N Are you receiving Home Health? Y N
Occupation, including activities that comprise your workday: _____

Health Habits:
Smoking Currently: ☐ Yes ☐ No Alcohol: ☐ Current ☐ Past ☐ Never
Do you exercise beyond normal, daily activities and chores? ☐ Yes ☐ No
Hobbies/Leisure Activities: _____

Do you have pacemaker/defibrillator? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
List anything you are allergic to (medications, latex, etc) : _____

Medical/Surgical Information:

Have you RECENTLY (past 3 months) had any of the following symptoms (check all that apply)?

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ difficulty walking
- ☐ changes in bowel or bladder function (including but not limited to color, frequency)
- ☐ chest pain
- ☐ vision changes
- ☐ difficulty swallowing
- ☐ muscle weakness
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ cough
- ☐ coordination problems
- ☐ pain at night
- ☐ constipation/diarrhea
- ☐ loss of appetite
- ☐ shortness of breath
- ☐ fainting
- ☐ falls
- ☐ headaches
- ☐ joint pain/swelling

Please check if you've EVER had any of the following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ chest pain/angina
- ☐ high blood pressure
- ☐ circulation problems
- ☐ blood clots
- ☐ stroke
- ☐ anemia
- ☐ bone or joint infection
- ☐ chemical dependency (i.e., alcoholism)
- ☐ Fibromyalgia
- ☐ depression
- ☐ lung problems
- ☐ tuberculosis
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ other arthritic condition
- ☐ bladder/urinary tract infection
- ☐ kidney problem/infection
- ☐ sexually transmitted disease/HIV
- ☐ pelvic inflammatory disease
- ☐ broken bones
- ☐ thyroid problems
- ☐ diabetes
- ☐ osteoporosis
- ☐ multiple sclerosis
- ☐ epilepsy/seisure
- ☐ eye problem/infection
- ☐ ulcers
- ☐ liver problems
- ☐ hepatitis
- ☐ pneumonia
- ☐ other _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ high blood pressure
- ☐ diabetes
- ☐ stroke
- ☐ depression
- ☐ tuberculosis
- ☐ thyroid problems
- ☐ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications/supplements you are currently taking (INCLUDING pills, injections, skin patches, and/or over the counter medications/supplements/vitamins)(mark any that are new):

_____

_____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries/conditions for which you have been hospitalized, including dates:

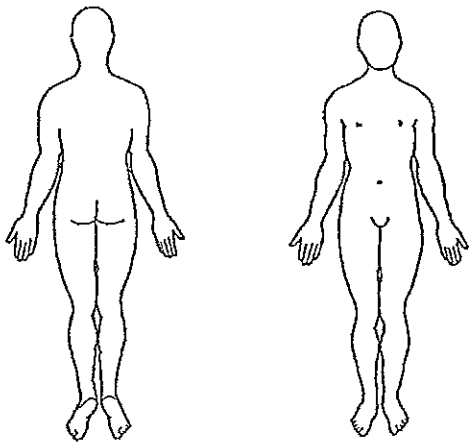
_____

Current condition/chief complaint

Roughly, when did your symptoms start?_____
What caused your symptoms? _____
My symptoms are currently: _____
Treatment received so far for this problem (chiropractic, injections, etc): _____
Please list special tests performed for this problem (x-ray, MRI, labs, etc): _____
What are your goals for Physical therapy? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right:



My symptoms currently: ☐ Come and go ☐ Constant
☐ Are constant, but change with activity
☐ Wake me up at night

Describe your sleeping habits:
☐ No difficulty ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

Symptoms are worst: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise
Symptoms are best: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____ The best your pain has been over the past week: _____ The worst your pain has been over the past week: _____

Using the 0 to 10 the scale, with 0 being *"complete function"* and 10 being the *"unable to do anything"* please describe:

0 1 2 3 4 5 6 7 8 9 10

ASSIGNMENT AND RELEASE

We agree to submit a claim to your insurance company and/or attorney based on the information you have provided to us.

You agree to accept responsibility for co-payments, deductibles, co-insurances, medical care and other services that are provided to you which are not specifically covered by your healthcare for any reason, i.e. a failure on your part to obtain necessary authorizations or appropriate referrals. Other examples include refusals by your insurance company to pay benefits because of circumstances which preclude coverage, i.e. injuries on the job (worker's compensation), and injuries sustained by motor vehicles (no-fault) or pre-existing conditions.

This agreement is not intended to conflict with or circumvent the provisions of contracts and governmental regulations.

This agreement is not intended to conflict with any grievance procedure that maybe available to you.

I hereby authorize payment directly to Triton Healthcare, Inc.

Signature:_____ Date _____

Dry Needling Consent Form

Dry needling is a valuable adjunct treatment for chronic pain or stiffness, and it can be used to deactivate myofascial trigger points. Like any medical procedure, there are possible complications.

While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure. With the dry needling technique, a fine, flexible and sterile needle is used. We practice standard precautions during treatment. The purpose of the needling is to release shortened bands of muscle caused by abnormal functioning of the nervous system. A local inflammatory process is stared to encourage healing. No medications are injected.

Dry needling may cause an increase in pain for one to three days followed by an expected improvement in the overall pain state. The increase pain is related to a local chemical response and an overactive shortened muscle bands that have not been released and to the soreness caused by the "twitching" of the muscle.

Any time a needle is used there is a risk of infection. However, we are using new, disposable and sterile needles, and infections are extremely rare. A needle may be placed inadvertently in an artery or vein. If an artery or vein is punctured with the needle, a hematoma (or bruise) will develop. If a nerve is touched, it may cause paresthesia (a prickling sensation) which is usually brief, but it may continue for a couple of days. When a needle is placed close to the chest wall, there is a rare possibility of a pneumothorax (air in the chest cavity). Fortunately, all these complications are not fatal and are readily reversible.

Patients are requested to inform practitioners about conditions such as pregnancy, pacemakers, and the use of blood thinners or issues with blood pressure, or immunosuppressant medications prior to the treatment.

I have read or had read to me the above; I understand the risks involved with dry needling. I have had the opportunity to ask questions I had and all of my questions have been answered. I consent to examination and treatment at Triton Healthcare Inc., including dry needling.

Signature:_____ Date:_____

Print name:_____

Witness:_____

Authorization for Disclosure Of Protected Health Information

I, _____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws,[2] subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Name(s): _____

Organization(s): _____

Address: _____

2. I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above:

Name(s): _____

Organization(s): _____

Address: _____

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy note must be separate):

4. Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space):

5. I understand that I may revoke this authorization at any time by sending a letter to the person or organization listed in paragraph one, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. If I do not sign this form or if I later revoke my authorization, the services provided to me by the person or organization listed in paragraph one will not be affected in any way.

6. This authorization expires on _____, or in the event that
(date)
_____, whichever comes first.
(event)

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____

Signed

_____

Printed Name

_____

Date

* Further information on HIPPA requirements and patient rights available upon request.

[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, and future physical or mental health of an individual; 2) the provision of health care to an individual; 3) the past, present, and future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.

[2] These laws apply to health plans, health care providers, and health care clearinghouse.