

Confidential Patient Information

C & K Healing Touch Physical Therapy PC / 295 Madison Ave Ste 410 New York NY 10017 / Ph:(212)682-2750 Fax:(212)682-6588

This information is confidential. If we do not believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you.

Date: _____ Patient Name: _____

Home/Cell Phone: _____ SSN: _____ Age: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: S M W D How many children do you have? _____

Occupation: _____ Work Phone: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Spouse Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

Medical History:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> CVA	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ra	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Angina	<input type="checkbox"/> Child Ds	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HTN	<input type="checkbox"/> Heart	<input type="checkbox"/> High BP
<input type="checkbox"/> Asthma	<input type="checkbox"/> CHF	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleed Ds	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Gout	<input type="checkbox"/> PVD	<input type="checkbox"/> VD	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Claudication		<input type="checkbox"/> Stomach Ulcer		<input type="checkbox"/> Osteoporosis

Past Surgeries: _____

Please List other doctors consulted for present complaints and injuries:

Name: _____ What kind of Dr. _____

When Consulted: _____ Diagnosis: _____

Treatment/X-rays: _____

How long did you see the doctor? _____ How frequently? _____

Results: _____

Name: _____ What kind of Dr. _____

When Consulted: _____ Diagnosis: _____

Treatment/X-rays: _____

How long did you see the doctor? _____ How frequently? _____

Results: _____

Patient Questionnaire and Informed Consent

Graston Technique® (GT) is a unique, evidence-based form of instrument-assisted soft tissue mobilization that enables clinicians to effectively and efficiently address soft tissue lesions and fascial restrictions resulting in improved patient outcomes.

GT uses specially-designed stainless steel instruments with unique treatment edges and angles to deliver an effective means of manual therapy. The use of the GT instruments, when combined with appropriate therapeutic exercise, leads to the restoration of pain-free movement and function.

Please answer the following questions. Read the statements concerning Graston Technique® (GT) and sign below. If you have any questions, please speak with your clinician.

- | | | |
|---|-----|----|
| 1. Do you bruise easily? | Yes | No |
| 2. Do you bleed for a long period of time after you cut yourself? | Yes | No |
| 3. Are you taking blood thinners or anticoagulants? | Yes | No |
| 4. Do you take aspirin on a regular basis? | Yes | No |
| 5. Do you take cortisone on a regular basis? | Yes | No |
| 6. Have you ever had inflamed veins or blood clots? | Yes | No |
| 7. Do you have surgical implants in your body? | Yes | No |
| 8. Do you have diabetes or kidney disease? | Yes | No |
| 9. Do you currently have any infections? | Yes | No |
| 10. Do you have uncontrolled high blood pressure? | Yes | No |
| 11. | | |

Graston Technique® may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

Graston Technique® is designed to minimize discomfort; however the above reactions are normal, and in some instances desirable and unavoidable.

The Graston Technique® protocol has several basic components. Your clinician will determine the protocol for you.

1. Warm up of the treatment area.
2. Graston Technique® Treatment.
3. High repetition, low load exercise.
4. One to three 30-second stretches.
5. Low repetition, high weight exercise.
6. Ice therapy.
7. Stretching/rehabilitation exercise.

All components of Graston Technique® have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print your name _____ Date _____

Your signature _____