Sentinel Health MT *PATIENT INTAKE FORM*

Name: _____DOB ____/____/_____ Age _____Date: _____/_____/_____

Address: _____ZIP:_____

Phone: Hm: (____)_____ Cell: (____)_____ Wk: (____)_____

Do you accept text messages: Y / N email: _____

Age: _____ Birthdate: _____/_____/_____ Gender: M / F

Occupation: _____ Employer: _____

Referral Source: _____

In Case of Emergency:

Name:_____ Relationship: _____

Phone: (____)_____ Hm/C/Wk

Patient Condition

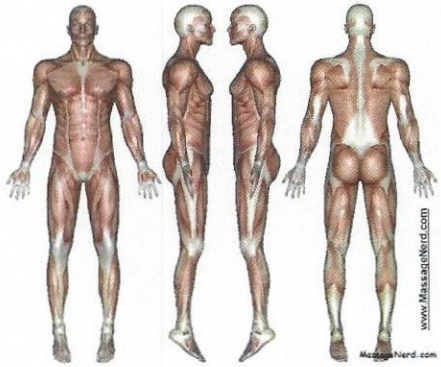
Have you ever had a professional massage? Y / N How long ago? _____

Reason for Visit: _____

When did symptoms appear? _____

Is this condition becoming progressively worse? _____ Constant? _____ Changes? _____

Place an X on the diagram where you continue to have pain, tingling, or numbness.



Rate your pain from 1 (least)-10 (most): _____

Type of Pain: Sharp _____ Dull _____ Throbbing _____Numbness _____
Aching _____ Shooting _____ Burning _____ Tingling _____Cramps _____

Stiffness _____ Swelling _____ other _____

How often do you have the pain? _____ Does it come & go? _____

Does it interfere with: Work( ) Sleep( ) Daily Routine( ) Recreation( )

Activities that are painful/difficult to perform: Sitting( ) Standing( ) Lying( ) Going up Stairs( ) Down Stairs( )

Is the injury related to an accident? Auto( ) Work( ) Home( ). Date of injury____/____/____

Give a brief explanation of accident: _____

_____

_____

Habits:

Smoking? _____ per day?
Caffeine? _____ drinks per day?

Alcohol? _____ drinks per week?

Do you exercise? Y / N What type? Weights, Run/Walk, Cycling, Yoga/Pilates, other: _____

_____x per week Mild/Moderate/Heavy intensity?

HEALTH HISTORY

What treatments have you received for your condition? Medication( ) Surgery( ) Chiropractic( )
Physical Therapy( ) None( )
other:_____

Please an *X* by all conditions that you have had in the past or at present:

AIDS/HIV _____
Anemia_____
Hypertension_____
Appendicitis_____
Arthritis_____ type_____
Asthma _____
Bleeding Disorder_____
Blood Clots_____
Bruise Easily_____
Cancer_____ type _____
Diabetes_____
Epilepsy/Seizures___when____
Fractures _____
Fibromyalgia_____
Goiter_____
Gout_____
Heart Disease_____
Hepatitis_____
Hernia_____
Herniated/Bulging Disc_____
where _____
Herpes/Shingles_____
Kidney Disease_____
Liver Disease_____
Migraines/Headaches_____
Mononucleosis_____
Tuberculosis_____
Neuropathies _____
Osteoporosis _____
Pacemaker _____
Implantable Port _____
Parkinson's Disease _____
Pinched Nerve _____
Polio _____
Neuromuscular condition_____
type _____
Prosthesis/Implants _____
Rheumatic Fever _____
Thyroid Disorder_____
Scoliosis_____
Stroke_____
Tumors/Growths_____
Ulcers_____
Vascular Disease_____
Wears Contacts/Dentures_____
Pregnant_____ trimester _____
Other: _____
_____
_____

Injuries/Surgeries you have had: **Description** **Date**

Falls/Accidents _____ ____/____/____
Broken Bones _____ ____/____/____
Dislocations _____ ____/____/____
Surgeries _____ ____/____/____

Medications, Supplements, Herbs: _____
_____

Allergies: (include latex and environmental)_____

TREATMENT REALEASE

Please Read Carefully and Sign & Date Where Indicate

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential. I may submit a signed request for release of medical records under HIPAA guidelines.

I agree to inform the therapist if I experience any pain or discomfort beyond my level of tolerance during this session so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Tanya Geraci who is dually licensed as a massage therapist and nurse practitioner is currently treating me under the auspices of a licensed massage therapist and the treatment I receive is not a substitute for medical examination. Any suggestions of therapies, treatments, medications, supplements, or conditions are only recommendations and should be further discussed and approved by my primary care provider.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and I understand that there shall be no liability on the therapist's part should I fail to do so. I acknowledge that I have read and understand the release and I hereby give my consent to receive massage services and/or other bodywork or treatment from Tanya Geraci and I acknowledge and agree that I am doing so at my own discretion.

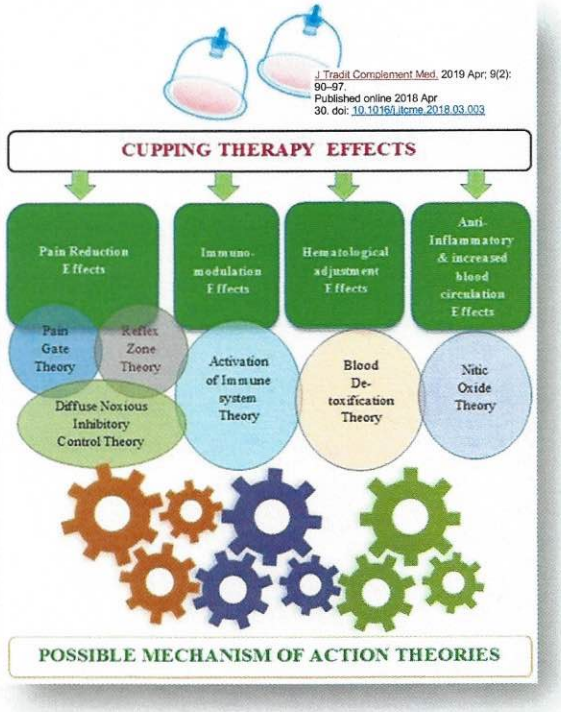
Print Name: _____
Signature: _____ Date: ____/____/____

Cupping/Gua Sha Therapy Release Form

Cupping Therapy/Gua Sha have similar risk & benefits. Cupping Therapy/Gua Sha may be used interchangeably & with other manual therapies or alone. They can be used to reduce pain perception, increase ROM, increase tissue perfusion and reduce disability. Cupping Therapy/Gua Sha is not suitable for everyone. There are risks associated with performing these therapies on individuals with the following conditions. You must inform your massage therapist/practitioner if you have any of the following conditions, which may make Cupping Therapy/Gua Sha, contraindicated or may require your therapist/practitioner to alter the treatment.

Cupping Therapy *is form of alternative healing in which silicone/plastic therapy cups are placed on your skin using various methods to achieve the desired therapeutic affect. The cups may be applied for seconds or remain on the skin for several minutes. The degree of suction is based on desired outcome & patient tolerance. Skin changes due to Cupping Therapy vary from no marks on the skin, some redness or various degrees of pigmented circular marks.*

Gua Sha *is an alternative healing method in which a smooth-edged tool is used to scrape to your skin in long, downward strokes. This motion raises small, red, rash-like dots that show under your skin called petechiae. There may be slight discomfort during therapy & soreness following for a few days. Your treatment will be adjusted to your level of tolerance.*



Please check the following that applies to you.

- ○ Bruises
- ○ Pregnancy
- ○ Blood clot(s)
- ○ Cardiovascular disease
- ○ Diabetes
- ○ Neuropathy
- ○ Inflammatory skin conditions
- ○ Autoimmune condition (MS, Lupus, RA, etc.)
- ○ Open wounds, sores, or thinning skin
- ○ Peripheral vascular disease
- ○ Hypotension or Hypertension
- ○ Heat sensitivity
- ○ Cancer (with or without treatment)
- ○ Compromised immune system
- ○ Varicose veins
- ○ Edema or Lymphedema
- ○ Under the influence of drugs or alcohol
- ○ Antibiotics
- ○ Blood thinning medications

PLEASE ADVISE YOUR THERAPIST IF YOU DO NOT WANT ANY OBVIOUS SKIN MARKING

I, _____, have read and understand the conditions that make Cupping Therapy/Gua Sha Therapy contraindicated. The massage therapist/practitioner has discussed this information with me and provided opportunity for any questions. I have disclosed any and all health risk factors.

□ I understand the information contained on this form and confirm that I **do not** have any of the above conditions.
(Or)
□ My condition(s) of _____ is/are listed above and therefore make(s) cupping contraindicated or used with caution. Given this knowledge I hereby give my full consent to receive Cupping Therapy/Gua Sha and take full responsibility of any side effects or harm that may come from my receiving Cupping Therapy/Gua Sha. I understand that I will be receiving cupping as an adjunct form of healthcare only and that this therapy is not meant to replace appropriate medical care. I understand the risks of bruising and muscle soreness that may occur directly or indirectly from Cupping Therapy/Gua Sha. I release the massage therapist/practitioner and business of any and all liability for any harm that may unintentionally occur during my treatment(s).

□ I consent to Cupping Therapy □ I consent to Gua Sha Therapy

Signature _____ Date _____

Dry Needling Consent And Information Form

What is dry needling?

Dry needling is a form of therapy and in which sterile fine needles are inserted into myofascial trigger point (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. Dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low back pain, and other musculoskeletal conditions of dysfunction. Intramuscular electrical stimulation (IES) may be used in conjunction with dry needling to facilitate release and further pain relief.

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 than 1 per 10,000 (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 appear 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 provider and go to the ER. 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).

Is there anything your practitioner needs to know?

1. *Have you ever fainted or experienced a seizure? YES/NO*
2. *Do you have a pacemaker or any other electrical implant? YES/NO*
3. *Are you currently taking anticoagulants blood thinners; e.g. Aspirin, warfarin, Coumadin? YES/NO*
4. *Are you currently taking any supplements that may contribute to blood thinning; e.g. Fish oil, coconut oil, flax, garlic etc. YES/NO*
5. *Do you have any type of bleeding or clotting disorder? YES/NO*
6. *Are you currently taking antibiotics for an infection? YES/NO*
7. *Do you have a damaged heart valve, metal prosthesis or other risk of infection? YES/NO*
8. *Are you pregnant or actively trying for a pregnancy? YES/NO*
9. *Do you have a metal or latex allergies? YES/NO*
10. *Are you allergic to betadine or chlorhexidine? YES/NO*
11. *Are you a diabetic or do you suffer from impaired wound healing? YES/NO*
12. *Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? YES/NO*
13. *Have you eaten in the last two hours? YES/NO*
14. *Do you have an extreme fear of needles? YES/NO*

Only sterile single–use, disposable needles are used in this clinic.

STATEMENT OF CONSENT

I confirm that I have read the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at anytime.

Signature: _____

Printed name: _____ Date: _____

GRASTON TECHNIQUE

Talking Points

Explanation for Patients

Procedure detects and treats areas of soft tissue lesions or adhesions in muscles, tendons and ligaments that can lead to pain and dysfunction.

In the healing process, our body attempts to repair muscles, tendons and ligaments with "scar tissue," much like the scar that forms on the skin when you have scraped or banged your knee. Scar tissue tends to be weaker and less flexible than normal, healthy, undamaged tissue. Scar tissue limits range of motion and in many instances causes pain, which prevents the patient from functioning as they did before the injury.

When viewed under a microscope, normal tissue can be organized in a couple of different fashions: dense, regular elongated fibers running in the same direction, such as tendons and ligaments; or dense and loose, irregular with fibers running in multiple direction . In either instance, when tissue is damaged, it will often heal in a fibrotic, haphazard manner, which results in a restricted range of motion and, very often, pain and functional limitations.

GT uses specially-designed stainless steel instruments with unique treatment edges and angles to glide along a patient's muscle, tendons or ligaments. When knots or bands of scar tissue are encountered, both the clinician and the patient sense a restriction or a granular feeling from the instrument.

Non-invasive, GT allows the clinician to get as deep into the tissue as necessary to invoke change, yet be sensitive to patient pain and tolerance. As the instrument slider across the afflicted area, it pulls the adhered fibers to the side and releases them. Over time, this process will reduce or eliminate the adhered fibers, restoring motion and eliminating the pain associated with it. It rebuilds a soft tissue injury into healthy functioning tissue.

The instruments enhance what the clinician's hands can feel - substantially improving the ability to detect and treat soft-tissue dysfunctions. An unaided hand is hard pressed to detect and break up as much scar tissue as the stainless steel instruments can.

In most cases, GT will be used in conjunction with manual and other somatic therapies to achieve desired resultsWhen used alone, patients usually receive 1-2 treatments per week during the span of 4-5 weeks. Most patients have a positive response by the 3rd or 4th treatment. The average number of GT sessions per episode of care averages between 6-12 for more chronic conditions.

GT is not designed to be painful or cause excessive bruising. Occasionally, minor discomfort during the procedure and some bruising afterward may be experienced. GT clinicians are trained to recognize these symptoms and adjust treatment intensity to minimize their occurrence, while realizing the benefits of the technique. GT does not need to be considered "painful" to be effective. I inform patients to let me know when they are experiencing discomfort an¥time during treatment.

Most patients are able to function and continue to perform their regular functions at home, work or play.

Benefits of GT:

Decreases overall time of treatment
Fosters faster rehabilitation/recovery
Reduces need for anti-inflammatory medication
Resolves chronic conditions thought to be permanent
Patient continues to engage in everyday activities

Is GT New?

The concept of cross fiber massage is not new. Graston Technique® is grounded in the works of Dr. James Cyriax, a British orthopedic surgeon. The use of our specially designed instruments and protocol is new.

Graston Technique® has become standard protocol in universities and hospital-based outpatient facilities as well as industrial on-site treatment settings such as Indiana University and the University of Michigan. The technique is also being used at industrial settings and by NBA, NHL, NFL, and Major League Baseball trainers.

GT has been used to treat the following acute and chronic conditions:

Achilles Tendinitis/osis (ankle pain)
Carpal Tunnel Syndrome (wrist pain)
Cervical Sprain/Strain (neck pain)
Fibromyalgia
Lateral Epicondylitis/osis (tennis elbow)
Lumbar Sprain/Strain (back ~pain)
Medial Epicondylitis/osis (golfer's elbow)
Patello-femoral Disorders (knee pain)
Plantar Fasciitis/osis (foot pain)
Rotator Cuff Tendinitis/osis (shoulder pain)
Scar Tissue
Shin Splints
Trigger Finger
Women's Health (post-mastectomy and Caesarean scarring)

Graston Technique® can be used to treat any movement system dysfunction that has been determined to have a soft tissue component.

Providers

Graston Technique® is used by more than 21,750 clinicians-including chiropractors, athletic trainers, hand therapists, occupational and physical therapists.

GT is used at some 2,540 out-patient facilities, 73 industrial on-sites, 366 professional and amateur sports organizations, and is part of the curriculum at more than 42 respected colleges and universities.

Only clinicians who have been trained and accredited in the Graston Technique® Basic Training course are qualified to obtain the Graston Technique® instruments and apply the technique to treat patients. **(Note:** This establishes your uniqueness.)

GRASTON® TECHNIQUE

Patient Questionnaire and Informed Consent

Please answer the following questions. Read the statements concerning Graston Technique® 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

Graston Technique® (GT) is a system of instrument-assisted soft tissue mobilization that utilizes a set of six instruments that aid the GT trained clinician in detecting treatable soft tissue lesions. The GT instruments consist of six stainless steel instruments of various sizes and contours. GT is a form of treatment used to "break up" or "soften" scar tissue, thus allowing for the return of normal function in the area being treated.

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 which may include the following components that are selected after a comprehensive evaluation has been performed.

1. Warm up of the treatment area.
2. Graston Technique® Instrument Assisted Soft-Tissue Treatment.
3. Therapeutic exercise to include appropriate stretching and/or strengthening which will be performed before, during or after your GT treatment.
4. Ice therapy.

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: _____

SENTINEL HEALTH, LLC

Privacy Practices Acknowledgment & Contact Consent$_{MT}$

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "**Notice**") from Sentinel Health, LLC ("**Sentinel Health**") and that I have been provided an opportunity to review it.

I understand that:

- Sentinel Health can change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.
- Sentinel Health can and will use my information for purposes of my treatment, payment for treatment, and healthcare operations.
- The Notice explains in more detail how Sentinel Health may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- Sentinel health can change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

*I authorize Sentinel Health to contact me regarding my Protected Health Information (**PHI**), such as but not limited to, appointment reminders, lab results, referrals, return phone calls.., via the following methods.*

CHECK ALL THAT APPLY:

☐ Cell Phone ____-____-_____ ☐Work Phone _____-_____-_____ ☐Home Phone _____-_____-_____

email ☐Home _____@_____ ☐Work_____@_____

Fax ☐Work _____-_____-_____ ☐ Home _____-_____-_____

Name: _____ Date:_____

Signature: _____ DOB:_____

Relationship to Patient: _____

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment Form

Patient Name:_____ Date of Birth: _____

I attempted to obtain the patient's (or the patient's representative's) signature on the **HIPAA Notice of Privacy Practices Acknowledgment Form**, but was unable to do so as documented below:

Reason: _____ Name: _____

Signature: _____ Date: _____

SENTINEL HEALTH, LLC
Louisville, Kentucky

Notice of Privacy Practices

This notice describes how health information about you maybe used and disclosed and how you may get access to this information. Please read completely and if you have questions or concerns please feel free to discuss them.

This office has always safeguarded your health information and we will continue to treat each patient with the utmost respect.

We reserve the right to change this notice of privacy practices and terms of this notice at anytime as permitted by law. We reserve the right to apply the new terms in our privacy practices to all health information that we maintain including health information we created or received before the changes.

Use and disclosures of health information:
We use and disclose health information about you for treatment, payment, and healthcare operations. *For example: should we need to disclose your health information in order to make a referral for specialty services, labs, diagnostic exams, or in order to secure health insurance payment.*
Terms defined:
Treatment: We may use or disclosure information to a physician or other healthcare provider currently providing treatment to you.

Payment: We may use and disclose health information to obtain payment for services provided to you.

Healthcare operations: We may use and disclose healthcare information in connection with healthcare operations that may include; assessment and quality improvement activities, reviewing the competence or qualifications of our healthcare professionals, evaluation of practitioners and providers conducting training programs, accreditation, certification, licensing, or other credentialing activities. In the event this office is ever sold, information may be shared to this provider or administrator of care, or if you are referred to another provider for treatment, information maybe shared with this provider. All those working under the auspices of Sentinel Health, LLC are required to sign an agreement of confidentiality.

To your family and friends: We may only disclose your health information to you. With your written consent to release health information, we may disclose your health information to a family member, friend, or other designated persons to the extent necessary to help with your healthcare or for payment of your healthcare.

Persons involved with your care: In the event of your incapacity or emergency circumstances, we may make the determination, based on our professional judgment, to disclose your health information. We will only disclose the most pertinent information's to be persons most directly involved. In case of emergency, we may disclose or use health information to notify or assist in the notification of a family member, your personal representative, or another person responsible for your care to provide notice of your location, your general condition, or death.

If you have a family member is in the room with you they will here your healthcare information. Please do not ask a family member to come back with you if you do not want them to know your healthcare information.
Your permission will be required for any persons to pick up supplements, supplies, x-rays, or other similar forms of health information.

Marketing: Your information will not be used for marketing communications without your previous written consent.

Required by law: We will use or disclose your health information when we are required to do so by law.

Abuse or neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health and safety or the health and safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment reminders: we may use or disclosure health information to provide you with appointment reminders such as voice mail, text message, or a phone call to your residents answered by a family member, postcard, or letter. **If you do not wish such messages to be left in such a manner please notify our office.**

YOUR RIGHT
Access: You have the right to a copy of your treatment records provided you make a written request. These records will be photocopies of your existing records. We reserve the right to charge for repeated request for copies.
Disclosing accounts: you have the right to receive a list of instances in which we disclose health information for purposes other than treatment, payment, health care operations, or certain other activities during the last six years. If you request this information more than once in one year there will be a reasonable fee.
Restrictions: You have the right to have additional restrictions on the use or disclosure of your health information. This request must be in writing. We are not required to agree to these restrictions, but if we do, we must abide by them.
Amendments: You have the right to request in writing that your healthcare information be amended. Your request should clearly state your reason for request. Your request maybe denied