PATIENT NAME_____

Functional Dry Needling Information and Consent Form
The Sharp End Physcial Therapy LLC

Definition according to IDAHO ADMINISTRATIVE CODE IDAPA 24.13.01 – Rules Governing the Bureau of Occupational Licenses Physical Therapy Licensure Board

"A skilled intervention performed by a physical therapist that uses a thin filiform needle to penetrate the skin and stimulate underlying neural, muscular, and connective tissues for the evaluation and management of neuromusculoskeletal conditions, pain and movement impairments. "

Dry needling is accomplished by inserting a tiny monofilament needle into a tight muscle band in order to decrease trigger point activity.
This technique can be helpful resolve muscle pain, tension and to promote healing.
Dry Needling is not traditional Oriental Acupuncture. It is a medical treatment that relies on a Physical Therapists diagnostic knowledge of tissue and mechanical dysfunction to be effective.

While complications are rare, they must be considered by the patient prior to giving consent for treatment.

Risks:

1. Pneumothorax. While this occurrence is exceptionally rare, there is risk of accidental puncture of the chest wall resulting in deflation of a lung. The main symptom is shortness of breath which may last for several days to weeks. Medical attention should be sought. Diagnosis, would likely require an X-ray. A severe puncture may require hospitalization for re-inflation of the lung. The Physical Therapist is highly trained and will take every precaution to prevent its occurrence.
2. Injury to a blood vessel may cause a bruise. Bruising is somewhat common occurrence.
3. Infection: reasonable precautions are taken to prevent infection and its occurrence is rare, however it does happen occasionally.
4. Injury to a local nerve. The Physical Therapist is a professional who is highly trained in anatomy and FDN technique and will take great precautions to avoid nerves. Nerve injury is rare but may occur.
5. Occasionally there is minimal bleeding

Patient's Consent: I understand that no guarantee has been made regarding the results of this procedure and that it may not cure my condition. The treatment may require a series of sessions. This consent will cover the initial treatment and all subsequent treatments performed by the Physical Therapist(s) and/ or Therapy Facility. If the treatment occurs outside of the physical therapy clinic, for example at a sporting event or venue, the event/ venue has no responsibility whatsoever for the treatment nor for the result, nor for any complication(s) incurred to the patient. My therapist has discussed the procedure with me and has informed me regarding the possibility of serious side effects.

Please answer the following questions:

1. Have you ever fainted or experienced a seizure?	❐ Yes	❐ No
2. Do you have a pacemaker or any other electrical implants?	❐ Yes	❐ No
Do you have any other implants?	❐ Yes	❐ No
3. Are you currently taking anticoagulants (ex: Aspirin, blood thinners)?	❐ Yes	❐ No
Do you have a clotting disorder?	❐ Yes	❐ No
4. Are you currently taking antibiotics for an infection?	❐ Yes	❐ No
5. Do you have a damaged heart valve, metal, or other risk of infection?	❐ Yes	❐ No
6. Are you pregnant?	❐ Yes	❐ No

7. Do you suffer from metal allergies? ☐ Yes ☐ No
8. Are you a diabetic or do you suffer from impaired wound healing? ☐ Yes ☐ No
9. Do you have Hepatitis B, C, HIV, or any other infectious disease? ☐ Yes ☐ No
10 Have you had any surgery in the last 12 weeks? ☐ Yes ☐ No

RECENT SURGICALPROCEDURE, DATE_____

_____

I certify that I have truthfully and completely answered the health screening questions above.

INITIAL_____

I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to manage any complications which may result.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

_____ _____
Patient or Authorized Representative Date

_____
Printed Name of Patient or Authorized Representative, Relationship to patient

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

_____ _____
Physical Therapist Date