Arizona Medical Yoga Professionals
Raquel Lines, PT, PYT-C
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INFORMED CONSENT

Patient Name:_____ Today's Date:_____/_____/_____

Date of Birth:_____/_____/_____ Age:_____ Gender: Male/Female

Address:_____City:_____State:_____Zip:_____

Cell Phone:_____Home Phone:_____

Emergency Contact Name:_____Phone:_____

Email:_____ Fax:_____

Referring MD/PA/CNP:_____ Phone:_____

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Informed Consent & Liability Release: I (or on behalf of the patient/client), consent for Raquel Lines, PT, PYT-C to administer physical therapy, manual therapy, medical therapeutic yoga, neuromuscular re-education and therapeutic exercises/activities to me as considered necessary and proper in the diagnosis and treatment of the patient/client. I have been informed and acknowledge that in using the facility, equipment, and services of AZ Medical Yoga Professionals, I do so at my own risk. I understand and I am aware that strength, flexibility, and cardiovascular exercise including the use of equipment, is a potentially hazardous activity and that I am voluntarily participating in these activities. I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would limit my participation. I acknowledge that I have either had a physical examination and have been given my physician's approval to participate in exercise, or that I have decided participate in exercise without the approval of my physician. I recognize that I am protected by patient privacy laws and hereby authorize the office of Raquel Lines, PT, PYT-C to release my records to my referring physician's office for the purposes of facilitating improved quality and continuum of care. I hereby certify that I have read the contents of this Informed Consent and Release of Liability. I agree that the foregoing obligations shall be binding of me personally, as well as upon my family and my heirs, executors, administrators, and assigns.

Patient/Parent/Client Signature: _____Date_____/_____/_____

Financial & Cancellation Policy: All services will be rendered will be based on a fee-for-service transaction, to be paid immediately following each session. Please write check out to Raquel Lines. Any scheduled appointment NOT cancelled within 24 hours will result in a $50 charge late cancellation or no-show fee. Exceptions include acute illnesses and emergency situations. Please notify Raquel by email, voicemail or text message as soon as possible if you have to cancel your appointment.

Patient/Parent/Client Signature: _____Date_____/_____/_____

☐ **Please check box if you agree to using Texting/Email as an Option for Coordinating Appointments, Home Program, and relevant Information as necessary.** Initial: _____

Reason for visit/ Main complaint or concern:

_____
_____
_____

Past treatment for this concern/complaint and response:

_____
_____
_____

Diagnostic Tests and results:

_____
_____
_____

Current aggravating factors & effect:

_____
_____

Current easing factors & effect:

_____
_____

What are your TOP 3 GOALS for therapy?

1._____
2._____
3._____

Lifestyle & Habits:

- Overall sleep quality? (circle) Excellent Good Fair Poor
  How many hours/night? (circle) 0-2 2-4 4-6 6-8 8-10+
  Sleep position? (circle) back side stomach
  Bed quality? (circle) Excellent Good Poor/Sagging
  How old is your bed? _____months/years
  Is your bed: (circle) Very Firm Firm Medium-Firm Plush Very Plush
- Typical Workday? (indicate %) Standing_____ Sitting_____ Walking_____ Stairs_____
  Frequent Change of Positions_____ Exercise/Activity_____
- Typical dietary intake: Fruits/vegs_____ Protein_____ Carbohydrates_____ Fats_____
  GMO awareness_____ organic_____ Food Allergies/sensitivities_____
  Special diets_____ Gluten_____ Paleo_____ Vegan_____
- Alcohol Consumption? _____ (circle): Wine Beer Liquor Daily/Weekly/Monthly/sporadic/Never
- Tobacco Use? _____ (circle): Cigarettes Cigars Chew Daily/Weekly/Monthly/sporadic/Never

Regular Exercise Program &/or current limitations:

_____
_____

What hobbies and/or recreational activities do you enjoy & are you able to participate in them?

_____
_____

Spiritual or Religious Practice:

_____
_____

MEDICAL SCREENING QUESTIONNAIRE

Please review the following questions so that your physical therapist has a better idea of your general health. It is imperative that your therapist provides the safest exercise and treatment program for each participating individual. It is also upon the patients' and therapists' best interest to have a verbal or written physician's release so that medical clearance is established before beginning an exercise program.

Please answer the following questions to the best of your knowledge:

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

____ Lumbar Pain
____ Cervical/Thoracic Pain
____ Headaches/Migraines
____ Numbness/Tingling
____ Pinched Nerve
____ Sciatica
____ Herniated or Bulging Disc
____ Osteoarthritis (DJD)
____ Degenerative Disc Disease
____ Rheumatoid Arthritis (RA)
____ Scoliosis
____ Spondylolisthesis
____ Osteoporosis/ Osteopenia
____ Gout
____ Leg or foot cramping
____ Ligamentous Laxity or EDS
____ Ankylosing Spondylitis (AS)

____ Diabetes
____ Chest Pain/Angina
____ Shortness of Breath
____ High Blood Pressure
____ COPD
____ IBS
____ Asthma
____ High Cholesterol
____ Kidney Problems
____ Adrenal Fatigue
____ Hyper/Hypothyroidism
____ Stroke
____ Heart Disease
____ Heart Attack
____ Anemia
____ Hepatitis
____ Nausea/vomiting/vision
____ Celiac Disease

____ Wounds/Ulcers
____ Multiple Sclerosis
____ Dementia/Alzheimers
____ Restless Leg Syndrome
____ Lyme Dz/Autoimmune Dz
____ Fibromyalgia/Chronic Fatigue
____ Aids/HIV
____ Dental/Jaw Problems
____ Chron's Disease
____ Personality Disorder
____ Schizophrenia
____ ADD/ADHD
____ Depression
____ Anxiety
____ Bipolar Disorder
____ Autism/Asperger's Disorders
____ Addiction
____ Other mental health

____ C-Section or Traumatic Births
____ Hernia (Inguinal/Hiatal/Diastasis/Other)
____ Hormonal Imbalance (PMDD/Menopause)
____ Endometriosis
____ Incontinence (Circle: Bowel/Bladder OR Urge/Stress/Mixed)
____ Urinary Tract Infections
____ Dizziness/Vertigo/Loss of balance/ Falls (How many falls within the last 12 months?_____)

____Tendonitis:_____
____Allergies:_____
____Fracture:_____
____Cancer:_____
____GeneticDisorders:_____
____HeadInjuryConcussion:_____
____MVA:_____
____Surgery:_____
_____
____Other:_____
_____

List all medications, doses, frequency & supplements you are currently taking (anti-depressants, pain meds, sleep aids, heart or blood pressure meds, cholesterol meds, vitamins, probiotics, etc.):

_____ _____ _____
_____ _____ _____
_____ _____ _____

List XRAYs, MRIs, CAT, NCV/EMG, BMD & other Diagnostic Tests that have been completed or ordered by your physician:

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all physicians, nurses, alternative medicine practitioners, etc. you have seen within the last 5 years (& diagnosis):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Social History (check):
____Lives alone ____Lives with spouse ____Lives with other family members or roommates
____Independent with Activities of Daily Living (ADLs)
____Needs Assistance with ADLS (circle): MINIMAL MODERATE MAXIMUM
____Involved with community

Circle YES or NO to these QUESTIONS:

1. Has your doctor ever told you that you have a heart condition and that you should only do physical activity recommended by a doctor?	YES	NO
2. Do you feel pain in your chest OR shortness of breath when you do physical activity?	YES	NO
3. In the past month, have you felt chest pain at rest?	YES	NO
4. Do you ever lose your balance because of dizziness?	YES	NO
5. Have you ever lost consciousness? Or sudden memory loss?	YES	NO
6. Do you have a bone or joint problem that could be worsened with physical activity?	YES	NO
7. Is your doctor currently prescribing meds for your blood pressure or heart condition?	YES	NO
8. Do you know of any other reason why you should not do physical activity?	YES	NO

**If you answered YES to one or more of these questions, please talk to your doctor BEFORE you start becoming more physically active. Tell your doctor about the questionnaire and to which questions that you answered YES.*If your health changes so that you answer YES to any one of the above questions, please tell your therapist. Ask whether you should change your physical activity plan.*

ADDITIONAL QUESTIONS:

1. Have you ever had a history of breathing or lung problems?	YES	NO
2. Are you currently taking medications that directly affect your heart, lungs, or circulatory system? (If YES, please list in “medications” column.)	YES	NO
3. Do you have a hernia or any condition that may be aggravated by lifting weights?	YES	NO
4. Do you have a chronic illness or condition?	YES	NO
5. Have you had surgery within the past 12 months?	YES	NO
6. Are you currently pregnant or have been within the past 3 months?	YES	NO
7. Have you had any recent weight loss or gain?	YES	NO
8. Any recent changes in vision or hearing?	YES	NO

**Please explain any YES answers below and list any information that you feel we should know before beginning therapy.*

_____
_____

COVID -19 QUESTIONS:

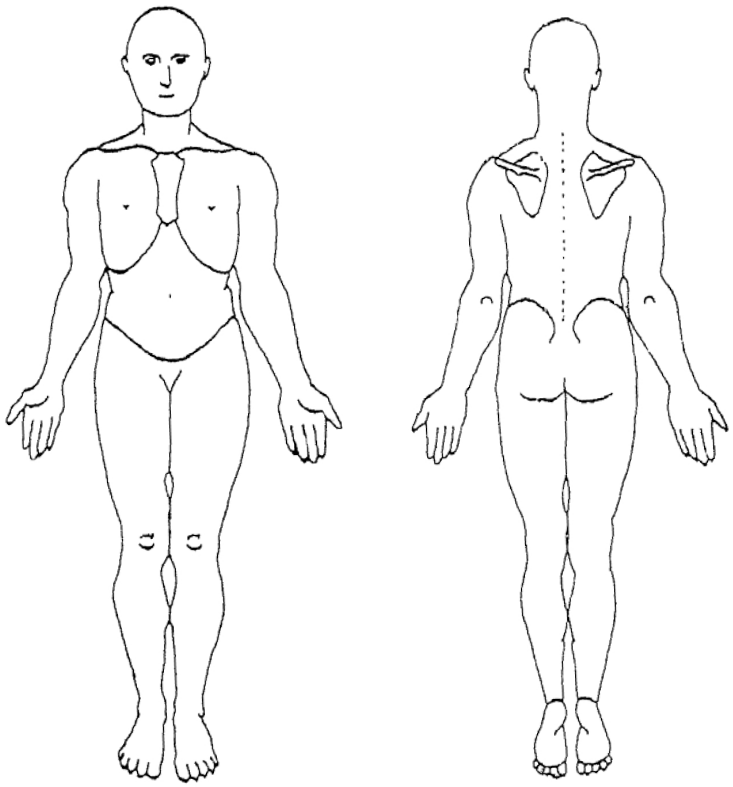
1. Have you been out of the state/country traveling in the past 2 weeks?	YES	NO
2. Have you had a fever, illness, or loss of taste/smell in the past 2 weeks?	YES	NO
3. Have you been around anyone that has been sick, ill, or tested positive for Covid?	YES	NO
4. Have you tested positive for Covid the past 2 weeks	YES	NO

Name: _____Date: _____

1. BODY DIAGRAM
Indicate your symptoms on the body diagrams using the symbols in the key below:
Key:

/////// Stabbing
XXX Burning
OOO Pins and Needles
++++ Numbness
AAAA Ache

If description is not found, circle area and write in what it feels like.



2. PAIN SCALE

On the line below, please make a line where you think your pain level is at when at rest (#1) and with activity (#2):

0 = no pain or symptoms
10 = the worst pain you've ever had

#1 REST: |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

#2 ACTIVITY: |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10