Mann Method
PT and Fitness, PLLC

13825 W. 85th Drive, Suite 200
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FUNCTIONAL DRY NEEDLING CONSENT FORM

Functional Dry Needling (FDN), also referred to as trigger point dry needling, is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits. FDN is based upon Western medical concepts, requires an examination and diagnosis, and treats specific anatomic structures selected according to physical signs. This can help resolve pain, decrease muscle tension, improve flexibility, and promote healing.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While serious complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks of the procedure:

The most serious risk with FDN is accidental puncture of a lung (pneumothorax). Other risks include injury to a blood vessel causing bruising, infection and nerve injury. These risks may have lasting complications and/or require further medical management and/or treatment, including but not limited to hospitalization and medical intervention.

I understand that I have the right to ask about these risks and have any questions answered about my condition prior to treatment. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. 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 explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure.

I, _____, hereby request and consent to the performance of FDN for the treatment of my condition by my physical therapist at Mann Method PT™ & Fitness, PLLC.

Please indicate if you have any of the following conditions:

Are you pregnant?	Yes	No
Are you immunocompromised?	Yes	No
Are you taking blood thinners?	Yes	No
Do you have a disease or infection which can be transmitted through bodily fluids?	Yes	No

(If you marked yes, please discuss with practitioner.)

_____ _____ _____

Print Name Patient Signature Date

_____ _____

Signature of Parent/Legal Guardian (to minor) Relationship to Patient

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