

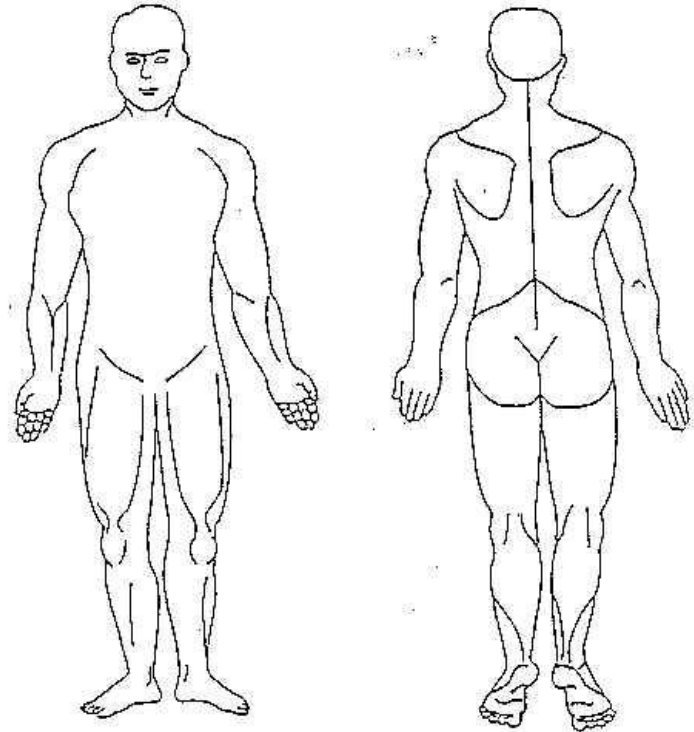
Name: _____ Pt No: _____

Date: _____ Consent Form Completed: Yes ☐ No ☐

Response to last Dry Needling Rx: _____

Pain Referral Pattern

CONTRA INDICATIONS	YES	NO
Pregnancy		
Anti-coagulants		
Haemophilia		
Malignant Tumours		
Open wounds		
Arteriosclerosis		
Aneurysms		
Allergies		
Epilepsy		



Posture: _____

ROM Before Dry Needling: _____

Functional Unit Affected: _____

Palpation: _____

Skin Sterilised: Yes ☐ No ☐ Expiry Date of Needles Used: _____

Muscle Needled	TrP Zones Needled	Side of Body Needled	Needle Size	Number of Needles Used	Twitch/Pain referral reproduced	Needle Grasp	Bleeding

Hot Pack Applied to Needled Muscles: Yes ☐ No ☐

ROM After Dry Needling Rx: _____

Stretches done: _____

Home Advice: _____