Integrated Manual Physical Therapy

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PATIENT INFORMATION:

Name:____ Date of Birth:_______________________________
Name of Parent/Guardian if Minor: ____
Address:____
Cell Phone:(   )_____________________________Home Phone:(   )__________________________________
Email:____ Hobbies/Occupation____
Emergency Contact: ______________________________ Phone:(   ) ____
Referring Doctor: __________________________________Phone:(   ) ____

FINANCIAL POLICY:

Integrated Manual Physical Therapy, PLLC (IMPT) provides physical therapy on a "fee at time of service" basis. By removing IMPT from the insurance companies, it does not have to limit the time or quality of treatment provided because of insurance company restrictions or elevate our rates to pay for billing services. I understand that I, the patient, am entering into care as a "cash-pay" client. By signing this agreement, I understand that IMPT will not be billing my insurance. I understand that my reimbursement benefits for Physical Therapy received at IMPT are out-of-network services and reimbursement is not guaranteed.

I agree to pay IMPT for my treatments at time of service, by cash or check unless other mutually agreed upon arrangements have been made. I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, **I will pay a cancellation fee of $75.__________________(initial)**

CONDITIONS FOR TREATMENT:

I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist can share with me opinions and available studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

I understand that in order for physical therapy treatment to be most effective, I must come to scheduled appointments and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist. I understand that IMPT asks me not to wear perfumes and strong scents to treatments.

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION:

I authorize the mutual exchange of information regarding myself between IMPT and the following persons or professionals:

____

____

ACKNOWLEDGEMENT OF RECEIPT OR UNDERSTANDING OF PRIVAVCY NOTICE:

I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations. I acknowledge that I have the right to receive a complete detailed copy of the ***NOTICE OF PRIVACY PRACTICES*** *upon request*.
_____________**(initial)**

CONSENT FOR TREATMENT OF VISCERAL AND MANUAL THERAPY:

The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The following information is to inform you of potential risks and benefits. I hereby voluntarily consent to physical therapy treatment.

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. You may experience tenderness, bruising, warmth, redness, aching, increased or decreased gastrointestinal motility, or other mild symptoms in general vicinity of tissues treated. This discomfort is usually temporary; if it does not subside in 24-48 hours, I agree to contact my physical therapist or physician.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. Improved energy mobility and gastrointestinal function. You will have greater knowledge about managing your condition and the resources available to you.

I, the patient, understand in order to best treat my condition that external manual therapy techniques may be performed in the anterior chest region *near* breast tissue, the anterior pelvic region *near* genital tissue and structures, and in the posterior and inferior gluteal region near rectum and pelvic bones including sacrum, coccyx, and ischial tuberosities. At any time if I am uncomfortable with any treatment I will immediately tell my therapist and I understand that I can decline any portion of the evaluation or treatment at any time.

I grant permission to all therapists I may see at IMPT to using all of the techniques they know, including Soft tissue mobilization, Visceral mobilization, Joint mobilization, Myofascial Release techniques, TMJ techniques, Proprioceptive Neuromuscular Facilitation (PNF) techniques, therapeutic exercises, neuromuscular re-education techniques and any other techniques believed to benefit me until I am discharged from care. _________________**(initial)**

***********I have read and fully understand the statements made on this form and agree that they apply to all treatments I receive from Integrated Manual Physical Therapy, PLLC and Veronika Campbell, PT, MPT, CSCS, NSC. I know I am responsible for all services received and I agree to pay for any and all services rendered at the time of service unless previous arrangements have been made. By signing this document I agree to the conditions stated in this form*******

Patient/Guardian signature ____ Date_____________________________

List Medications you are taking: ____

____

____

CHECK ALL THE STATEMENTS THAT ARE TRUE:

______Changes in my bladder or bowels function
_____ Swelling in ankles/feet or hands
_____ Numbness or tingling in feet/legs or hands/arms
_____ Unexplainably lost or gained more than 10 pounds
_____ I have had recent internal bleeding (ulcer, intestinal, etc.)
_____ I have an implant (IUD, pacemaker, stent, other)
_____ Eating changes my symptoms
_____ Blurred vision
_____ I feel dizzy
_____ I wake with night pain
_____ I have had a recent infection
_____ I am pregnant or plan to start

Name:____ DOB:________________________

MEDICAL and SURGICAL HISTORY

General ☐ Headaches / Migraines ☐ Blackouts ☐ Dizziness / Vertigo ☐ Sinus Problems ☐ History of Fall(s) ☐ Balance Disturbance ☐ Vision Loss ☐ Hearing Loss ☐ Memory Loss ☐ Insomnia	**Cardiovascular / Blood** ☐ High Blood Pressure ☐ Heart Attack / MI ☐ Heart Disease ☐ CHF ☐ Aneurysm ☐ Bleeding Disorder ☐ Blood Clots / DVT ☐ Anemia ☐ Chest Pain / Angina ☐ Arrhythmia ☐ High Cholesterol	**Digestive** ☐ IBS ☐ Crohn's Disease ☐ Celiac Disease ☐ GERD / Gastritis ☐ Ulcer ________________ ☐ Frequent Loose Stools ☐ Frequent Constipation ☐ Discomfort after meals ☐ Hiatal Hernia ☐ Swallowing Dysfunction ☐ Liver Disorder
Musculoskeletal / Orthopedic ☐ Osteoarthritis ☐ Fractures ____________ ☐ Compression Fracture ☐ Stress Fracture ☐ Dislocation ☐ Inguinal Hernia ☐ Hernia (other) ____________ ☐ Diastasis Recti ☐ Carpal Tunnel ☐ Thoracic Outlet Syndrome ☐ Spinal Stenosis ☐ Sciatica ☐ Spondylolisthesis ☐ Herniated Disc ☐ TMD ☐ Other Ortho Injuries ______________________	**Immune / Endocrine / Metabolic** ☐ Diabetes Type 1 or 2 (circle) ☐ Low Blood Sugar ☐ Hepatitis A B C (circle) ☐ HIV / AIDS ☐ TB ☐ Cancer ______________ ☐ Thyroid Dysfunction ☐ Autoimmune Disease ______________________ ☐ Osteoporosis / Osteopenia ☐ Gout ☐ Rheumatoid Arthritis ☐ Lupus ☐ Fibromyalgia ☐ Inflammatory Condition ______________________	**Surgical History** ☐ CABG / Bypass Surgery ☐ Pacemaker / Defibrillator ☐ Vascular Surgery / Stents ☐ Abdominal Surgery ☐ Gastric Bypass Surgery ☐ Hysterectomy ☐ Tubal Ligation ☐ Laparoscopy ☐ Bladder Surgery ☐ C – Section ☐ Hernia Surgery ☐ Gall Bladder Surgery ☐ Orthopedic Surgery ☐ Back / Neck Surgery ☐ Plastic Surgery ☐ Other Surgeries ______________________
Urogenital / Gynecological ☐ Urological Disorder ☐ Kidney Disease ______________________ ☐ Incontinence ☐ Endometriosis ☐ Dysmenorrhea ☐ Gynecological Disorder ☐ Fibroids / Cysts ☐ # of childbirths ____________	**Respiratory** ☐ Asthma ☐ Emphysema / COPD ☐ Pneumonia ☐ Allergies ☐ Sleep Apnea ☐ Deviated Septum ☐ Shortness of Breath ☐ Other Lung disorders ______________________	**Nervous System** ☐ Head / Brain Injury ☐ Stroke / TIA ☐ MS ☐ Peripheral Neuropathy ☐ Epilepsy / Seizure Disorder ☐ Parkinson's ☐ Neuromuscular Disorder ☐ Other Neuro disorder ______________________
Trauma ☐ Whiplash ☐ Motor Vehicle Accident ☐ Concussion ☐ Other Trauma	**Nutritional** ☐ Nutritional Deficiency ☐ Food Allergies ☐ Eating Disorder	**Family History:** ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Cancer

Name:____**DOB:**________________________________

BONES/JOINTS & AREAS OF PAIN: (Circle)

Lower Back   Middle back   Upper back   Neck   Head   Jaw

Abdomen   Tailbone   Pelvic Region   Ribs   Shoulders   Elbows

Wrist /Hands   Hips   Knees   Feet   Plantar fasciitis   Sciatica   Carpal tunnel

WHAT MAKES YOUR SYMPTOMS WORSE OR WHEN ARE THEY WORSE? (Circle)

Sitting   Standing   Walking   Getting out of bed   Getting up from sitting   Sleeping   Work

Morning   Evening   House Chores   Exercise or Sports   Sexual intercourse   Menses   Other______________________

WHAT MAKES YOUR SYMPTOMS BETTER? (Circle)

Heating pad   Ice pack   Resting in bed   Resting in Chair   Walking   Exercise   Stretching   Medication   Other ______________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

Physical Therapy   Acupuncture   Chiropractic   Massage   Medication   Surgery   None   Other

Types of treatments that helped:____

WHAT ARE YOUR GOALS OF PHYSICAL THERAPY:____

Please mark an X for areas of PAIN or SYMPTOMS on diagram below:

Please rate your symptoms on scale of **0 to 10** (with **0= no pain** and **10= the worst pain** imaginable/like you need to go to emergency room)

Current __________/10

Best______________/10

Worst____________/10