Integrated Manual Physical Therapy

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MEDICAL INFORMATION UPDATE FOR CURRENT PATIENT INFORMATION:

Name:_____ Date of Birth:_____
Address:_____
Cell Phone:( )_____ Email:_____
Emergency Contact: _____Phone:( ) _____
Referred by: _____Phone:( ) _____

PLEASE LIST ANY CHANGES TO YOUR HEALTH OR NEW DIAGNOSES:

_____
_____

PLEASE UPDATE ANY SURGICAL HISTORY IN PAST 5 YEARS:

_____
_____

PLEASE CIRCLE ANY NEW OR CURRENT AREAS OF PAIN/SYMPTOMS :

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

CIRCLE ALL THE WORDS THAT DESCRIBE YOUR SYMPTOMS:

Numbness Tingling Stabbing Burning Aching Throbbing Tender Shooting

Constant Sharp Intermittent Other_____

PLEASE LIST WHAT MAKES YOUR SYMPTOMS BETTER AND WORSE :

_____

LIST ALL MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING:

_____
_____
_____

WHAT ARE YOUR CURENT GOALS OF PHYSICAL THERAPY

Name:_____Date of Birth:_____

CONSENT FOR TREATMENT OF VISCERAL AND MANUAL THERAPY:

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 Veronika Campbell, PT, MPT, CSCS, NSC, IMPT, and any contract physical therapists it uses to provide to me using all of the techniques they know believed to benefit me until I am discharged from care._____**(initial)**

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 privacy 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 received a copy of your condensed *NOTICE OF PRIVACY PRACTICES*. I know that I have the right to receive a complete detailed copy of the privacy notice upon request. _____**(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 and any contract therapist used. I know I am responsible for all services received and IMPT does not accept insurance for its services. I agree to pay for any and all services rendered at the time of service unless previous arrangements have been made.*********

Printed name Signature of client Date