manual+
sports physical therapy

MOVE BETTER. FEEL BETTER. LIVE BETTER.

PATIENT HISTORY FORM

Name: _____ Weight: _____ Height: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Email: _____

Emergency Contact Name: _____ Number: _____

Gender: M / F

Pacemaker: Yes / No

Smoker: Yes / No

Pregnant: Yes / No

Occupation: _____

Past Surgeries (list & date): _____

_____

Current Medications (Rx & over-the-counter): _____

_____

_____

Past Medical History: Have you ever been told you have any of the following?

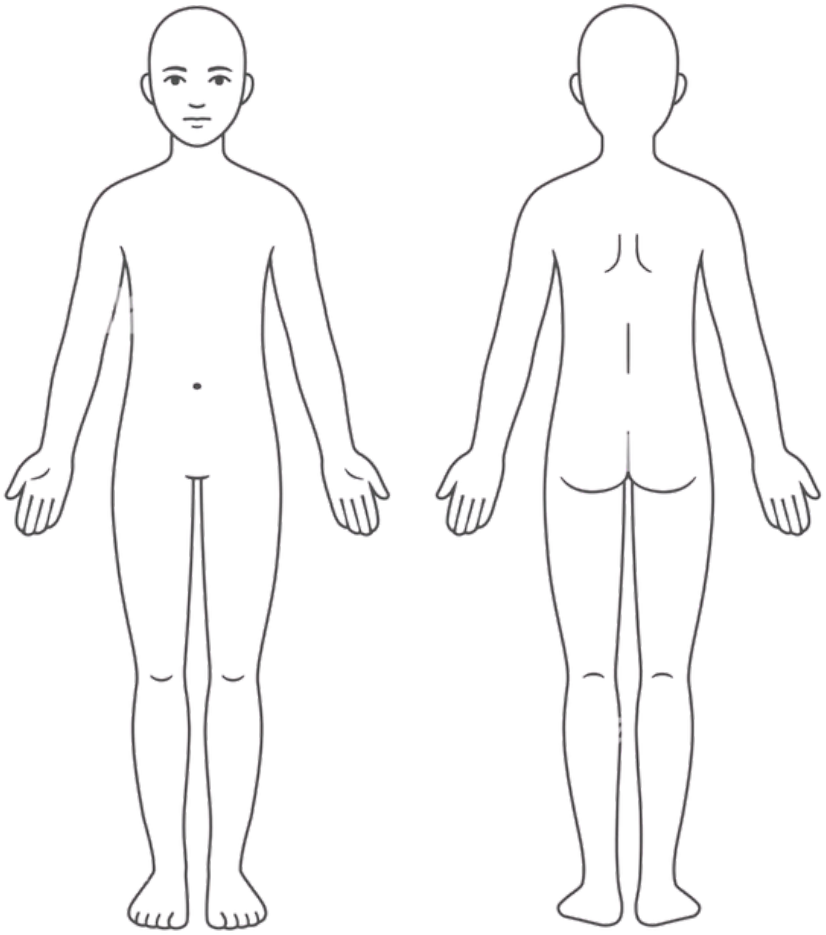
Cancer	Yes	No	Blood Clots	Yes	No
Heart Problems	Yes	No	Infectious Diseases	Yes	No
High Blood Pressure	Yes	No	Lung Problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis/Osteopenia	Yes	No	Fibromyalgia	Yes	No
Thyroid Problems	Yes	No	Kidney Disease	Yes	No
Rheumatoid Arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Others _____		

Currently: Are you experiencing any of the following? (circle all that apply)

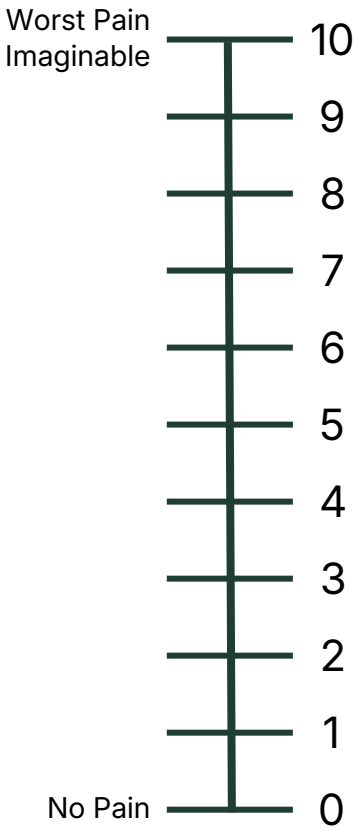
Fever / Chills / Sweats	Poor Balance (falls)	Unexplained Weight Loss	Pelvic Pain
Numbness / Tingling	Changes in Appetite	Difficulty Swallowing	Changes in Bowel & Bladder Functions
Depression	Shortness of Breath	Night Pain	
Dizziness	Nausea / Vomiting	Headaches	

Name: _____ Date: _____

Body Chart: Mark the areas where you feel your symptoms.



Pain Scale:
On the scale below, cirlce the number which best represents the average level of pain you have experienced over the last 48 hours.



Current History:

What date (approximately) did your present symptoms start? _____

How? (gradually, suddenly, injury) _____

How have your symptoms changed? (circle one) Getting Better About the Same Getting Worse

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other testing for this problem? Yes/No (specify)_____

What treatments have you received for this problem so far? _____

How did you hear about us? _____

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FINANCIAL RESPONSIBILITY, POLICIES, AND CONSENT

Assignment of Benefits

I certify that I have insurance coverage and assign directly to Manual & Sports Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered.

I authorize the release of any information necessary to secure payment of benefits and authorize the use of this signature on all insurance submissions.

Financial Responsibility

I understand that my insurance will be billed as a courtesy; however, I am ultimately responsible for all charges, whether or not they are covered by my insurance.

I understand that:

- Insurance verification is not a guarantee of payment
- I am responsible for knowing my benefits and coverage limitations
- Any services not covered or authorized by my insurance are my responsibility

Payment is due at the time of service for all co-payments, deductibles, co-insurance, and non-covered services.

Self-Pay Agreement

I understand that if I do not have active insurance coverage, choose not to use my insurance, or if my benefits have been exhausted, I am responsible for payment in full at the time services are rendered.

Current self-pay rates are as follows:

- Initial Evaluation: $225
- Follow-Up Treatment Sessions: $120

I understand that these rates are subject to change and that I will be informed of any changes prior to treatment.

APPOINTMENT POLICIES

Cancellation & No-Show Policy

Patients are required to provide at least 24 hours' notice for cancellations or rescheduling.

Appointments canceled with less than 24 hours' notice, as well as missed appointments, will incur a fee of $65.00 per occurrence.

This fee is not covered by insurance.

Late Arrival Policy

Patients arriving more than 15 minutes late may be required to reschedule and may be subject to the missed appointment fee.

Card on File

A valid payment method may be kept on file and charged for applicable fees or outstanding balances.

Attendance
Repeated missed or late-canceled appointments may result in modification or discontinuation of scheduling privileges.

Prescription Requirement
I understand that it is my responsibility to provide a valid and up-to-date prescription from my referring physician.

I understand that I will not be treated if my prescription is expired or not on file, and that failure to provide a valid prescription may result in interruption or delay of care.

It is my responsibility to ensure updated prescriptions are provided prior to scheduled appointments.

Return to Care/Re-Evaluation
I understand that if I have not attended physical therapy for an extended period of time, I may be required to schedule a re-evaluation before additional treatment visits can be provided. This determination is based on clinical judgment, the status of my plan of care, and applicable insurance requirements.

Consent to Treat
I authorize Manual & Sports Physical Therapy to provide evaluation and treatment as deemed necessary.

I understand that physical therapy is not an exact science and no guarantees have been made regarding outcomes.

I understand that my account must remain in good standing to continue treatment.

Acknowledgement of Privacy Practices
I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

Patient Name: _____ Date:_____

Patient Signature: _____

MANUAL & SPORTS PHYSICAL THERAPY

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