

# 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 Practitioner: \_\_\_\_\_

## 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. I understand that I, the patient, am entering into care as a fee for service 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, check, or Zelle 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 the full visit fee.** \_\_\_\_\_ (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 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.

**IMPT IS A PERFUME FREE ENVIRONMENT** (because many health conditions can be triggered by perfumes/fragrances). I understand that IMPT asks me not to wear perfumes, strongly scented haircare or skin care products to the treatment session. \_\_\_\_\_ (initial)

## CONSENT FOR MUTUAL EXCHANGE OF INFORMATION:

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

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## 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 read the online HIPPA document and 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. 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

**MEDICAL and SURGICAL HISTORY**

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**BONES/JINTS & 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

Circle your current level of function from 1-10:

(Barley functioning) 1 2 3 4 5 6 7 8 9 10 (Full Function)

