Manus Physical Therapy, Inc.
900 East Indiantown Rd, #111
Jupiter, FL 33477
561-288-8810 diana@manuspt.com fax: 877-464-1813

Name:_____DOB:_____Age:____Date:_____

Address (street, city, ST, zip):_____

_____

Alternate Address:_____

Telephone: Home:_____Cellular:_____Other:_____

Email:_____ (* beside preferred contact method)

Referred by:_____Primary Care Physician:_____

Specialist Physician:_____; I don't have a specialist ☐ or PCP ☐

Who should be contacted in case of emergency:_____Phone:_____

Date of Last Physical Exam:_____; approx. Height_____; approx. Weight_____

Occupation:_____; Typical hours of sitting per day_____

Date of Onset of Current Complaint_____; Original symptom onset_____

Describe your primary symptom_____

_____

Secondary Symptoms_____

Goals for PT:_____

What activity or position makes it WORSE?_____BETTER?_____

Previous treatment for this condition:_____

Testing/Imaging: X-ray ☐ MRI☐ CT scan☐ EMG☐ Bone scan☐ Blood work☐

Please indicate body part imaged and when imaging was performed:_____

Manus Physical Therapy does not accept assignment of insurance benefits. All clients are expected to pay for services rendered at the time of appointment. Cash, Check, Credit Card, Health Savings Account are accepted.

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Medical History (☐) NAME_____DATE_____

NO	Past	Current	
☐	☐	☐	Osteoarthritis, Joint Pain or Swelling (acute or chronic): meds_____
☐	☐	☐	Joint Replacements: THR☐ L/R; TKR ☐ L/R; TSR L/R; reverse TSA
☐	☐	☐	Rheumatoid Arthritis: mediation_____
☐	☐	☐	Autoimmune Disorder: Lupus, IBS, Crohn's, Celiac, _____
☐	☐	☐	Osteoporosis; Fractured Bone _____; Osteopenia
☐	☐	☐	Cancer: type_____; year_____
☐	☐	☐	Heart Attack: year_____; stent_____; bypass_____
☐	☐	☐	Angina (chest or jaw pain related to exertion) or Palpitations
☐	☐	☐	High Blood Pressure: controlled with _____
☐	☐	☐	Liver or Gall Bladder surgery: year_____; Hepatitis_____
☐	☐	☐	High Cholesterol: controlled with _____
☐	☐	☐	Depression or Anxiety ☐☐☐ Diabetes (type I, type II) controlled with _____
☐	☐	☐	Environmental Allergies _____
☐	☐	☐	Vision or Hearing: corrected with_____
☐	☐	☐	Loss of Balance or Dizziness; I have fallen ____times in the last year.
☐	☐	☐	GI disturbance: ulcer, nausea/vomiting, GERD
☐	☐	☐	Bowel or Bladder Disturbance or Incontinence (urgency, frequency, constipation)
☐	☐	☐	Coordination with moving arms or legs
☐	☐	☐	Weakness of the arms, legs, back, or neck
☐	☐	☐	Headache: migraine, tension, cluster migraine
☐	☐	☐	Thyroid (deficiency, surgery, radiation) medication _____
☐	☐	☐	Pain that Wakes you at Night
☐	☐	☐	Unexplained Weight Loss or Loss of Appetite
☐	☐	☐	Pneumonia, Emphysema, COPD, Unexplained Cough, Bronchitis, Asthma
☐	☐	☐	Fever, Chills, Night Sweats
☐	☐	☐	Difficulty Sleeping
☐	☐	☐	Swelling in the feet or ankles
☐	☐	☐	Pregnancy: year_____, C-section ☐ year_____
☐	☐	☐	Auto or Cycling Accident: year_____; traumatic hospitalization_____
☐	☐	☐	Other major surgeries: _____
☐	☐	☐	Smoking (☐ I am aware that healing time is longer if I smoke)

Medications/Surgeries not already listed: _____

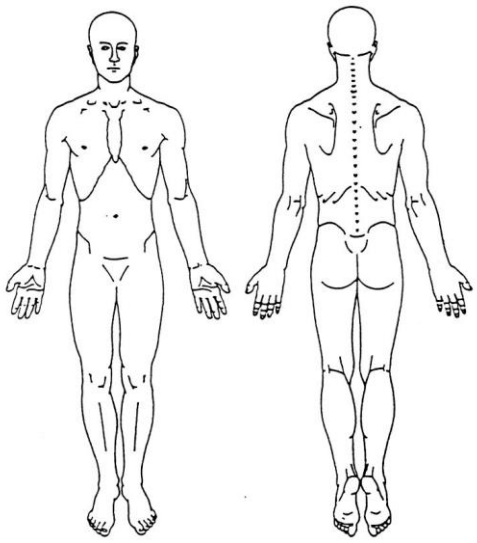
List Regular form of exercise:_____

Manus Physical Therapy, Inc. Name_____

PAIN or SYMPTOM DESCRIPTION

On the body diagram, use the following symbols to draw in your typical pain location.

//= ache X= stabbing pain S= tingling O= numbness



Use 0-10 to rate your symptom severity
(0=no pain, 10=excruciating pain)

Area #1	**Area #2**
Worst pain _____	Worst pain _____
Least pain _____	Least pain _____
Pain with Activity _____	_____

AGREEMENT TO RECEIVE TREATMENT

A. I understand that the information provided will be protected under the HIPAA Federal Act and used in accordance with the provisions set forward in the privacy statement. This information is posted and available for review._____(initial)

B. I understand that there are inherent risks associated with the treatment of physical disability, I am responsible for communicating associated symptoms and disclosing pertinent information relative to my care._____(initial)

C. I understand that Manus Physical Therapy, Inc. has a direct payment method of operation and I will be required to remit payment at the time of service. A fee schedule is attached. _____(initial)

D. I understand that whenever possible, my insurance carrier will be billed on my behalf; I am responsible for providing accurate information to assist in the electronic billing process._____(initial)

For tracking purposes, please indicate if health insurance is typically used:

Medicare □ Medicare +secondary □ PPO _____ □ Health Savings Account □ None □

BY SIGNING HERE, I ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND ACCURATE, THAT I AGREE TO THE TERMS A-D, AND I WISH TO PROCEED WITH TREATMENT.

_____SIGNATURE_____DATE

_____PRINTED NAME