Mann Therapies, LLC

Mann Method
PT and Fitness, PLLC

Today's Date:				PCP:	
PATIENT INFORMATION					
Last name: First:		Middle:		Marital status:	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address:					
Email address:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Chose clinic because/referred to clinic by (Please choose one option):	○ Doctor: ○ Other				
INSURANCE INFORMATION (Please give your insurance card to Sarah Mann.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance? ○ Yes ○ No			
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance: | Other:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: | Other:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mann Method PT™ & Fitness, PLLC and Mann Therapies, LLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

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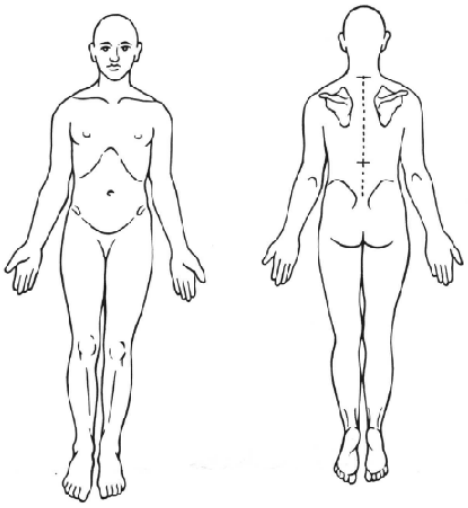
History of Present Condition

1. Why are you coming to therapy? What are your symptoms? _____

_____

2. Use the diagram below and the key to show where and what kind of symptoms you are having:



KEY

000	Numbness/tingling
XXX	Burning
ZZZ	Deep Ache
///	Sharp Pain
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3. When did this issue start?_____

4. Is your issue getting worse or better? _____

5. Have you had surgery for this issue: ○ Yes ○ No Date of Surgery:_____Surgical Procedure: _____

6. Imaging/Other tests: _____

7. What is your occupation? Are you currently working?_____

Symptoms / Limitations / Goals

Symptoms:

☐ Pain at worst (0-10)

☐ Pain at best (0-10)

☐ Numbness/Tingling

☐ Wake at night

☐ Clicking/Popping/Locking

Symptom description (intermittent/constant, etc): _____

_____

Change in symptoms when eat/sleep/other: _____

_____

Aggravates symptoms:

☐_____ Pain (0-10): _____ Duration: _____

☐_____ Pain (0-10): _____ Duration: _____

Eases symptoms:

☐_____ Pain (0-10): _____

☐_____ Pain (0-10): _____

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Medical History

Vitals: BP ___/_____ HR _____ RR _____

Have you or your immediate family member ever been told you have:		
	Self	Family
Cancer		
Diabetes		
Chest Pain		
Stroke		
Blood Clots		
Kidney Disease		
High Blood Pressure		
Emphysema		
Osteoporosis		
Rheumatoid Arthritis		
Osteoarthritis		
Asthma/Allergies		
Fainting		
Seizures		
Headaches		
Hepatitis		
Tuberculosis		
Do you have a pacemaker?		
Bowel/Bladder Problems		

In the past 3 months, have you experienced:	
Change in health	
Nausea/Vomiting	
Fever/Chills	
Unexplained weight change	
Numbness/Tingling	
Difficulty swallowing	
Bowel/Bladder Changes	
Shortness of Breath	
Dizziness	
Urinary Tract Infection	
Urinary Incontinence	
Jaw pain	
Fainting	
Loss of Consciousness	
Bowel/Bladder Problems	

Fall History	
Have you fallen 2 times or more in the past year?	
Have you been injured by falling in the past year?	

Surgery History/Broken Bones/Other significant injuries:			
Date:	Surgery/Injury:	Date:	Surgery/Injury:

Medications			
Medications	Dose	Frequency	Route