# Mann Method
## PT and Fitness, PLLC

| Today's Date: | | | | Pediatrician: | |
|---|---|---|---|---|---|

**PATIENT INFORMATION**

| Patient Last name: First: | Middle: | | | | |
|---|---|---|---|---|---|
| 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.: | | |
| Parent Occupation: | Employer: | | Employer phone no.: | | |
| Chose clinic because/referred to clinic by (Please choose one option): | ◯ Doctor:<br>◯ 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 PHYSICAL THERAPY AND FITNESS, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian signature _______________ Date _______________

## History of Present Condition

1. Why are you coming to physical therapy?______________________________________________________________

_______________________________________________________________________________

2. When did you first notice this issue start?_______________________________________________________

3. Is the issue getting worse or better? ____________________________________________________________

4. Does that patient have any pain? Y / N Where?___________________What helps?_____________________

5. Has the patient had surgery for this issue: ◯ Yes ◯ No Date:_______Surgical Procedure: __________

6. Has the patient had any of the following (circle all that apply):

Ultrasound / CT Scan / Xray or Radiograph Imaging / MRI / Other tests

7. Does the patient have a medical diagnosis? _____________________________________________________

8. Does the patient currently have any other therapies?_____________________________________________

9. Has the patient received physical therapy in the past?____________________________________________

## Pregnancy, Birth, and Developmental History

1. Were any fertility drugs used for this child's pregnancy? Y / N

2. Was this child's pregnancy in vitro? Y / N

3. Were any medications taken during the pregnancy? Y / N If so, name type and reason: __________________

_______________________________________________________________________________

4. Difficulties experienced during pregnancy (if any):__________________________________________

5. Medical complications during this pregnancy (if any): ___________________________________

6. At what month did your baby turn head down?___________________________________________________

7. Did your baby move a lot or a little, in general, during pregnancy?___________________________________

8. Were there changes in your birth plan or complications during delivery?______________________________

_______________________________________________________________________________

Did you experience (circle):

C-section Vaginal delivery Breech Sunnyside up Prolonged labor Forceps/Vacuum assisted delivery

Born at how many weeks_______Birth weight________Apgar scores________

As a newborn, did your child have:

NICU stay (number of days or weeks)_______

Oxygen______ Until what date: _______

Jaundice_____ Treatment:________

Difficulties latching/feeding_____

High glucose levels______

Low glucose levels_______

Hospitalization_______ # days____________Reason:____________________________________________

| Did or does your child have difficulty with any of the following? | | |
|---|---|---|
| | Currently | Previously |
| Latching/feeding from breast or bottle | | |
| Diaper changes | | |
| Bathing/washing hair | | |
| Eating | | |
| Reflux or GERD | | |
| Colic | | |
| Sleeping | | |
| Being calm or still | | |
| Using one arm or one leg (compared to the other) | | |
| Being dressed | | |
| Tracking an object | | |
| Reaching for objects | | |
| Sitting alone | | |
| Rolling | | |
| Crawling | | |
| Walking | | |
| Learning new skills | | |
| Car rides | | |
| Swings | | |
| Other | | |

## Medical History

Vitals: BP___/_____________HR_____________RR____________

| Has your child any one in your immediate family member ever been told you have (check all that apply): | | |
|---|---|---|
| | Child | Family |
| Seizures | | |
| Congestive heart failure | | |
| High Blood Pressure | | |
| Bowel/Bladder Problems | | |
| Motor delay | | |
| Headaches | | |
| Nystagmus | | |
| Strabismus | | |
| Stroke | | |
| Blood Clots | | |
| Kidney Disease | | |
| Asthma/Allergies | | |
| Rheumatoid Arthritis | | |
| Tuberculosis | | |
| Hepatitis | | |
| CMV | | |
| MTHFR gene mutation | | |

| In the past 3 months, has your child experienced (check all that apply): | |
|---|---|
| Regression in gross motor skills | |
| Reflux or colic | |
| Nausea/Vomiting | |
| Fever/Chills | |
| Unexplained weight change | |
| Changes in sleep | |
| Difficulty swallowing/eating | |
| Bowel/Bladder Changes | |
| Shortness of Breath | |
| Dizziness/clumsy | |
| Urinary Tract Infection | |
| Ear infection | |
| Seizures | |
| Fainting / Loss of Consciousness | |
| High fever | |
| Allergies | |
| Change in health | |

| Medications | | | |
| --- | --- | --- | --- |
| Medication Name | Dose | Frequency | Route |
| | | | |
| | | | |
| | | | |

| Surgery History/Broken Bones/Other significant injuries: | | | |
| --- | --- | --- | --- |
| Date: | Surgery/Injury: | Restrictions: | |
| | | | |
| | | | |
| | | | |
| | | | |