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 PHYSICAL THERAPY AND FITNESS, PLLC or insurance company to release any information required to process my claims.

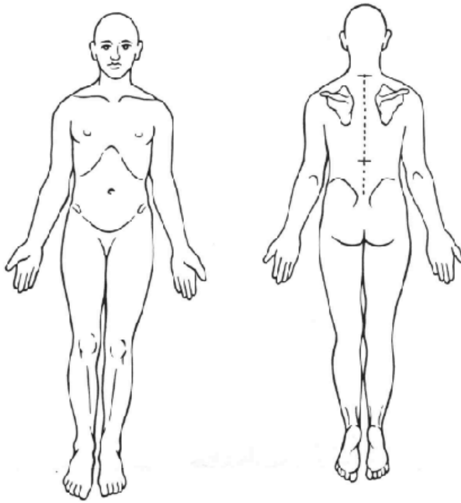
Patient/Guardian signature ______________________ Date ______________

History of Present Condition

1. Why are you coming to physical therapy? 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

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) Symptom description (intermittent/constant, etc): _______________

Pain at best (0-10) ____

Numbness/Tingling Change in symptoms when eat/sleep/other: ____________________

Wake at night ____

Clicking/Popping/Locking

Aggravates symptoms:

____________________________ Pain (0-10): _______ Duration: ____________

____________________________ Pain (0-10): _______ Duration: ____________

Eases symptoms:

____________________________ Pain (0-10): _________

____________________________ Pain (0-10): _________

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