MEDICAL HISTORY FORM

Patient Name: ________________________________Date of Birth: ____________ Date: ________________

Email: _____________________________ Address: ____

Emergency Contact (name, relationship to patient, & phone): ____

Height: ________ Weight: __________ Right/Left Hand Dominant: ______________ [ ] Male [ ] Female

What area are we treating you for?____

On a scale from 0-10 (0= no pain, 10= unbearable pain), please rate your current pain level: _______________

What makes the pain/problem better? ____

What makes the pain/problem worse? ____

Date of onset/injury/surgery:_____________ If injury, was it work related?_______ or Auto related?________

In the last year, have you had Physical Therapy and/or Chiropractic services anywhere else? [ ]Yes [ ]No

Date of next Physician's appointment?_______________ Dr.'s Name__________________________________

Which of the following tests have you had for this problem? (Please check) [ ] X-rays [ ] MRI [ ] CT Scan

[ ] Myleogram [ ] Blood Tests [ ] Other____

Do you have any of the following symptoms? (check all that apply) [ ]Pain [ ]Swelling [ ]Stiffness
[ ]Numbness [ ]Tingling [ ]Paralysis [ ]Weakness [ ]Dizziness [ ] Vertigo [ ] Other

Do you have or have you had any of the following?
(check all that apply)

	Y	N
Arthritis/Joint Disorders	[ ]	[ ]
Asthma/Respiratory Problems	[ ]	[ ]
Bowel/Bladder Disorder	[ ]	[ ]
Cancer	[ ]	[ ]
Chest Pain/Angina	[ ]	[ ]
Diabetes	[ ]	[ ]
Dizziness/Fainting	[ ]	[ ]
Headaches	[ ]	[ ]
Hearing Disorders	[ ]	[ ]
Heart Attack	[ ]	[ ]
Heart Disease	[ ]	[ ]
Heart Palpations	[ ]	[ ]
Hernia	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Hypoglycemia	[ ]	[ ]
Kidney Problems	[ ]	[ ]
Liver/Gallbladder Problems	[ ]	[ ]

	Y	N
Mental Health Disorders	[ ]	[ ]
Nervous System Disorders	[ ]	[ ]
Neurological Problems	[ ]	[ ]
Osteoporosis	[ ]	[ ]
Pacemaker	[ ]	[ ]
Poor balance/falling	[ ]	[ ]
Poor tolerance to heat/cold	[ ]	[ ]
Prosthesis/implants	[ ]	[ ]
Are you Pregnant?	[ ]	[ ]
Recent Fractures	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Seizures	[ ]	[ ]
Skin Abnormalities	[ ]	[ ]
Smoking/Alcohol Use/Abuse	[ ]	[ ]
Stroke/ CVA	[ ]	[ ]
Walking Difficulty	[ ]	[ ]
History of Physical Trauma	[ ]	[ ]
History of Emotional Trauma	[ ]	[ ]

Explain any YES responses and give related dates on the lines below:
____
____
____

Do you have any known allergies? [ ] Yes [ ] No If yes, please list ___________________________________

____

Do you have a sensitivity to latex or to tape/adhesive? [ ] Yes [ ] No

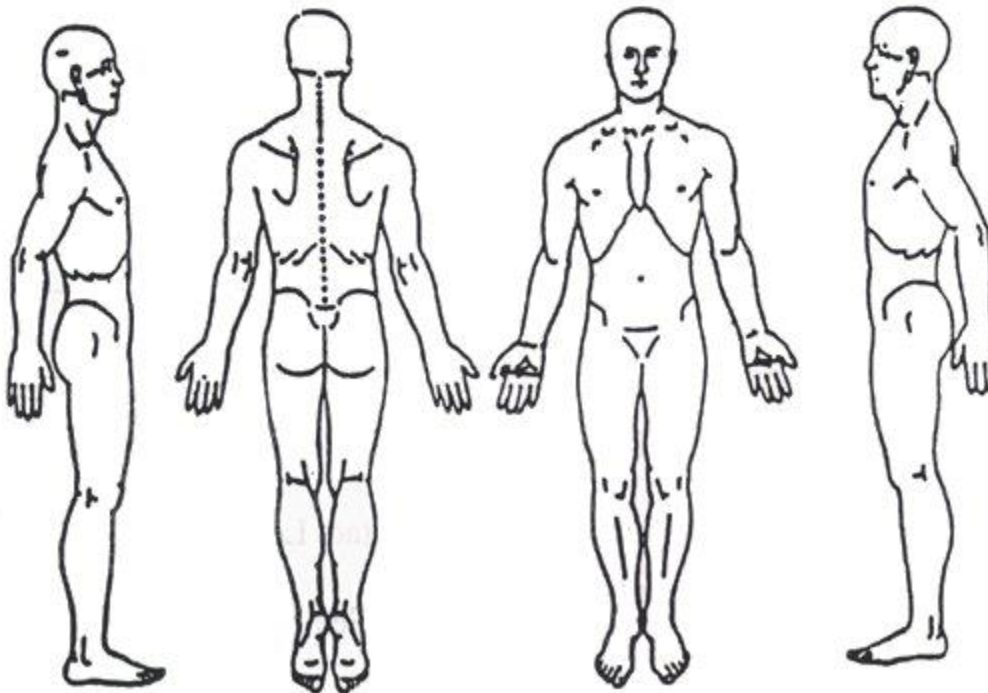
Do you work? [ ] Yes [ ] No If yes, what is your occupation?____

Please list your past surgical history with the dates of surgery included: _______________________________
____

Please mark the area on your body where you feel the described sensation. Include all affected areas. Use the appropriate symbol.

Numbness: = = = = Pins & needles: 000 000 000 Burning pain: XXX XXX XXX

Stabbing Pain: /// /// /// Aching Pain: (((((((((((((



What medications (over the counter and prescribed) have you taken in the last 24 hours?
____
____
____

How did you hear about Prana Functional Manual Therapy?____

Patient Policies and Authorizations

APPOINTMENTS:

Please arrive for your initial appointment at least **10 minutes early**.

If you are more than **15 minutes late** for your appointment without contacting us, your treatment may need to be adjusted or your appointment rescheduled.

Inform the front desk staff immediately of any demographic changes (phone number, address, insurance etc). Failure to notify us of changes to your insurance coverage and/or financial status my result in you being responsible for payment of services not covered by insurance carrier.

*****CANCELLATION POLICY:** A fee of $30.00 may be imposed after the second appointment that is missed or cancelled with less than 24 hour notice. ***

INSURANCE INFORMATION: We must emphasize that our relationship is with you, **not** your insurance company. Submission of insurance claims is a courtesy we extend to our patients but all charges are ultimately the patient's responsibility.

It is our policy to verify each patient's therapy benefits with their insurance company prior to their initial visit and to notify the patient of their coverage. Your coverage is a contract between you and your insurance company. It is important that you contact your insurance company directly with any questions for clarification and final decisions regarding your benefits. The patient is responsible to notify our office of any change in their insurance coverage.

If you have insurance coverage under a plan with which we do not participate you will be given the option to receive care as a self-pay patient. If you chose to use out of network benefits, you need to be aware that any balances not covered by your insurance become your responsibility.

Co-pays and self-pay amounts are due at the time of service. Any deductible and/or coinsurance amounts due from you will be billed to you.

PAYMENT: Prana Functional Manual Therapy is committed to providing you with the best care possible. If you have medical insurance, we will do everything possible to assist you in receiving your maximum insurance benefit.

We accept cash, personal check, money order and most major credit cards in person or by mail. Credit card payments are also accepted by phone.

Any outstanding balances are due within 30 days unless prior arrangements have been made.

PAYMENT PLANS: Please contact our billing specialist to work out a payment plan with our office. We will be happy to work with you in order to pay any balance due to our office.

***All balances that reach 90 days or older from the date of service may be sent to a collection agency. Accounts referred to a collection agency may be subject to a collection fee of 20% which will be added to the total balance due at the time the account is turned over. ***

I GIVE CONSENT FOR PRANA TO SEND THEIR NEWSLETTER TO MY EMAIL: (CHECK) ______YES _____NO

PAYMENT AGREEMENT: I agree that I am responsible for payment of charges which are not covered, allowed, or paid by my insurance company, Medicare, or any other Fund or third party payor. I understand that I will not be responsible for payment of any charges that Prana FMT is restricted from collecting by law or agreement. With the assignment described in this consent, I understand that any check for payment of benefits sent directly to me belongs to Prana Functional Manual Therapy.

___________________initials

CONSENT FOR TREATMENT: I hereby give my consent to receive treatment at Prana Functional Manual Therapy and authorize its employees to treat me in ways they judge beneficial to me. I understand my care may include evaluation, testing and treatment. I understand Prana Functional Manual Therapy cannot predict or guarantee the outcome of this care.
___________________initials

RELEASE OF INFORMATION: I authorize Prana Functional Manual Therapy to release all information including all or part of my medical records to my insurance company, employer (worker's compensation only), Medicare, or Fund or third party payor which may be responsible for payment of my benefits.

I authorize Prana Functional Manual Therapy to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

Prana Functional Manual Therapy may also release information to the following person(s):

Example: Attorney, Family members or friends

Name: _______________________________Relationship:___________________

Name:_______________________________Relationship:____________________

I have read and fully understand the patient policies and authorizations set forth by Prana Functional Manual Therapy and I agree to the terms of this policy.

Date:______________Signature:____

Prana Functional Manual Therapy follows Health Insurance Portability and Accountability Act (HIPAA). Should you like a copy of this Privacy Notification, please ask the front desk. Please sign below to acknowledge a copy is readily available should you want one.

Date:____________Signature:____

PATIENT-SPECIFIC FUNCTIONAL SCALE

Instructions:

Please list 3 activities that you are UNABLE to do or have moderate to extreme difficulty doing as a result of your injury or pain level. For each of the activities you list, RATE the level of difficulty you have performing each activity using 0-10 scale listed below. On the 0-10 scale, the HIGHER the number, the EASIER you can perform the activity. The LOWER the number, the more DIFFICULTY you have.

(Example: Dressing, sleeping, work duties, climbing stairs, etc)

Patient-specific activity scoring scheme (pick one number):

0= Unable to perform activity

10= Able to perform activity at same level as before injury or problem

Activity	0	1	2	3	4	5	6	7	8	9	10

(Therapist will score)

Total Score = sum of the activity scores/ number of activities Minimum detectable change (90%CI) for average score= 2 points Minimum detectable change (90%CF) for single activity score <<3points

PSFS developed by : Strateford, P., Gill, C, Westaway, M., &Binkley, J. (1995). Assessing disability and change on the individual patients: a report of a patient specific measure. Physiotherapy Candada, 47, 258-263.

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