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?____

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

What makes the pain/problem worse? ____

What makes the pain/problem better? ____

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

____

____

____

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

Condition			Condition		
Arthritis/Joint Disorders	[ ]	[ ]	Mental Health Disorders	[ ]	[ ]
Asthma/Respiratory Problems	[ ]	[ ]	Nervous System Disorders	[ ]	[ ]
Bowel/Bladder Disorder	[ ]	[ ]	Neurologic Problems	[ ]	[ ]
Cancer	[ ]	[ ]	Osteoporosis	[ ]	[ ]
Chest Pain/Angina	[ ]	[ ]	Pacemaker	[ ]	[ ]
Diabetes	[ ]	[ ]	Poor Balance/Falling	[ ]	[ ]
Dizziness/Fainting	[ ]	[ ]	Poor Tolerance For Heat/Cold	[ ]	[ ]
Headaches	[ ]	[ ]	Prosthesis/Implant	[ ]	[ ]
Hearing Disorders	[ ]	[ ]	Stroke/CVA	[ ]	[ ]
Heart Attack	[ ]	[ ]	Recent Fractures	[ ]	[ ]
Heart Disease	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
Heart Palpations	[ ]	[ ]	Seizures	[ ]	[ ]
Hernia	[ ]	[ ]	Skin Abnormalities	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Smoking	[ ]	[ ]
Hypoglycemia	[ ]	[ ]	Alcohol Abuse	[ ]	[ ]
Kidney Problems	[ ]	[ ]	Walking Difficulty	[ ]	[ ]
Liver/Gallbladder Problems	[ ]	[ ]	History of Physical Trauma	[ ]	[ ]
Are You Pregnant?	[ ]	[ ]	History of Emotional Trauma	[ ]	[ ]

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

____

____

____

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

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

[ ] Myleogram [ ] Blood Tests [ ] Other____

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

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?____

Doctors's Name_________________________________ Date of next Doctor's appointment?_______________

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

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

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: (((((((((((((

How did you hear about Prana Functional Manual Therapy?____

Patient Policies and Authorizations

APPOINTMENTS:

Please arrive for your initial appointment at least **15 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. ***

Please check box if you would like to opt out of Prana's newsletter emails: [_]

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 (PSFS)

Could you please identify THREE activities that you have difficulty with or are unable to do because of your problem? Please rate the level of difficulty you have with each activity using a 0-10 scale. On the 0-10 scale a higher number means the task is EASY, a lower number means that task is DIFFICULT.

0 = Unable to perform

10 = Able to perform activity at the same level as before your injury/problem

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

(For office use: Average Score = ____)

Patient Health Questionnaire (PHQ-4)

Over the last 2 weeks, how often have you been bothered by the following problems?

Please circle your answer	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

(For office use: Total Score = ____)