Advanced Motion Manual Therapy

CLIENT INFORMATION:

Name: _____ DOB: _____
Parent/Guardian if Minor and Relationship: _____
Address: _____
Cell Phone: ( ) _____ Home Phone: ( ) _____
Email: _____ Occupation: _____
Emergency Contact: _____ Phone: ( ) _____
Referring Provider: _____ Phone: ( ) _____
How did you hear of Advanced Motion Manual Therapy? _____

FINANCIAL POLICY:
Advance Motion Manual Therapy (AMMT), PLLC requires that all payment be paid at the time of service. By signing this agreement, I understand that AMMT will not be billing my insurance and I understand that I am entering into care as a cash-pay client. If I as the patient choose to submit claims myself, I understand that my benefits for Therapy services received at AMMT are out-of-network and reimbursement is not guaranteed by my insurance provider.

I agree to pay AMMT for all treatments at time of service, by cash or check unless other mutually agreed upon arrangements have been made. A fee of $25 is charged on all returned checks.

Failure to provide 24-hour notice or not showing for a scheduled appointment will result in a cancellation fee. I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel LESS than 24 hours in advance, **I will pay a cancellation fee of $90. _____(initial)**

Client/Guardian signature: _____ Date: _____

Print client name: _____

PRIVACY POLICY:
Acknowledgement of receipt and understanding of privacy notice
I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations. I acknowledge that I have the right to receive a complete detailed copy of the *NOTICE OF PRIVACY PRACTICES upon request*. AMMT has the right to change its Notice of Privacy Practices from time to time and that I may contact AMMT at any time to obtain a current copy.

Client/Guardian signature: _____ Date: _____

Authorization of Release of Health Information: I authorize the following individual(s) to have access to my personal health information.

Name:_____Relationship:_____Phone: _____
Name:_____Relationship:_____Phone: _____
Name:_____Relationship:_____Phone: _____

Client/Guardian signature: _____ Date: _____

Advanced Motion Manual Therapy

CONDITIONS / CONSENT FOR TREATMENT:

I understand that in order for manual therapy treatment to be most effective, I must commit to the discussed plan of care and perform the home program created for my benefit. If I have trouble with any part of my treatment program, I will discuss treatment options with my therapist before I consent to treatment.

I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

I waive *Advanced Motion Manual Therapy, PLLC and Darrell Larry,* OTR of any and all liability related to the administration of this unique hands-on treatment. By signing this document, I agree to the conditions stated in this form:

Client/Guardian signature: _____ Date: _____

Print client name: _____

CONSENT FOR TREATMENT OF MANUAL AND VISCERAL THERAPY:

The term "informed consent" means that the potential risks, benefits, and alternatives of manual therapy treatment have been explained to you. I hereby voluntarily consent to physical therapy treatment.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. Improved energy mobility and gastrointestinal function. You will have greater knowledge about managing your condition and the resources available to you.

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. You may experience tenderness, bruising, warmth, redness, aching, increased or decreased gastrointestinal motility, or other mild symptoms in general vicinity of tissues treated. This discomfort is usually temporary; if it does not subside in 24-48 hours, I agree to contact my therapist.

I, the patient, understand in order to best treat my condition that EXTERNAL manual therapy techniques may be performed in the anterior chest region *near* breast tissue, the anterior pelvic region *near* genital tissue and structures, and in the posterior and inferior gluteal region near rectum and pelvic bones including the sacrum, coccyx, and ischial tuberosities. At any time if I am uncomfortable with any treatment I will immediately tell my therapist and I understand that I can decline any portion of the evaluation or treatment at any time.

I grant AMMT therapists permission to use of all techniques they have been trained in, including soft tissue mobilization and myofascial release, visceral mobilization, joint mobilization, Active Release Technique, therapeutic exercises, neuromuscular re-education techniques and any other techniques believed to benefit me until I am discharged from care. _____ **(initial)**

Client/Guardian signature: _____ Date: _____

HEALTH HISTORY

Client Name: _____ DOB: _____

How can Advanced Motion Manual Therapy assist you? What are you looking to achieve?

_____

_____

Current Complaint:

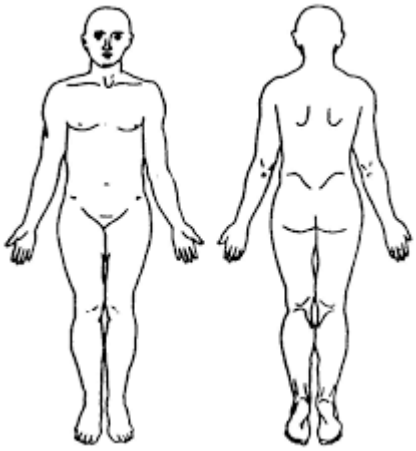
_____

_____

_____

Prior treatment for current condition:

____ Physical Therapy	_____ Chiropractic	_____ Massage Therapy
____ Surgery	_____ Medication	_____ Acupuncture



Mark areas of pain with a 'X'

Please rate your symptoms on scale of 0 to 10 (with 0 = no pain and 10 = the worst pain imaginable/need to go to emergency room)

Current pain: _____/10

Best pain: _____/10

Worst pain: _____/10

What makes your symptoms WORSE, including time of day:

_____

_____

What makes your symptoms BETTER, including time of day:

_____

_____

Diagnostic Testing:

____ X-Rays	_____ CT Scan	_____ Endoscopy / Colonoscopy
____ MRI	_____ Ultrasound	_____ Other

Relevant Family History:

_____

_____

MEDICAL and SURGICAL HISTORY

General □ Headaches / Migraines □ Blackouts □ Dizziness / Vertigo □ Sinus Problems □ History of Fall(s) □ Balance Disturbance □ Vision Loss □ Hearing Loss □ Memory Loss □ Insomnia	**Cardiovascular / Blood** □ High Blood Pressure □ Heart Attack / MI □ Heart Disease □ CHF □ Aneurysm □ Bleeding Disorder □ Blood Clots / DVT □ Anemia □ Chest Pain / Angina □ Arrhythmia □ High Cholesterol	**Digestive** □ IBS □ Crohn's Disease □ Celiac Disease □ GERD / Gastritis □ Ulcer _____ □ Frequent Loose Stools □ Frequent Constipation □ Discomfort after meals □ Hiatal Hernia □ Swallowing Dysfunction □ Liver Disorder
Musculoskeletal / Orthopedic □ Osteoarthritis □ Fractures _____ □ Compression Fracture □ Stress Fracture □ Dislocation □ Inguinal Hernia □ Hernia (other) _____ □ Diastasis Recti □ Carpal Tunnel □ Thoracic Outlet Syndrome □ Spinal Stenosis □ Sciatica □ Spondylolisthesis □ Herniated Disc □ TMD □ Other Ortho Injuries _____	**Immune / Endocrine / Metabolic** □ Diabetes Type 1 or 2 (circle) □ Low Blood Sugar □ Hepatitis A B C (circle) □ HIV / AIDS □ TB □ Cancer _____ □ Thyroid Dysfunction □ Autoimmune Disease _____ □ Osteoporosis / Osteopenia □ Gout □ Rheumatoid Arthritis □ Lupus □ Fibromyalgia □ Inflammatory Condition _____	**Surgical History** □ CABG / Bypass Surgery □ Pacemaker / Defibrillator □ Vascular Surgery / Stents □ Abdominal Surgery □ Gastric Bypass Surgery □ Hysterectomy □ Tubal Ligation □ Laparoscopy □ Bladder Surgery □ C – Section □ Hernia Surgery □ Gall Bladder Surgery □ Orthopedic Surgery □ Back / Neck Surgery □ Plastic Surgery □ Other Surgeries _____
Urogenital / Gynecological □ Urological Disorder □ Kidney Disease _____ □ Incontinence □ Endometriosis □ Dysmenorrhea □ Gynecological Disorder □ Fibroids / Cysts □ # of childbirths _____	**Respiratory** □ Asthma □ Emphysema / COPD □ Pneumonia □ Allergies □ Sleep Apnea □ Deviated Septum □ Shortness of Breath □ Other Lung disorders _____	**Nervous System** □ Head / Brain Injury □ Stroke / TIA □ MS □ Peripheral Neuropathy □ Epilepsy / Seizure Disorder □ Parkinson's □ Neuromuscular Disorder □ Other Neuro disorder _____
Trauma □ Whiplash □ Motor Vehicle Accident □ Concussion □ Other Trauma	**Nutritional** □ Nutritional Deficiency □ Food Allergies □ Eating Disorder	**Other:**

Medication and Supplements:
Please check the labels of ALL medications and supplements that you are currently or were recently taking and list them below:

Medication or Supplement:	Dosage:	Times per day:	Taking for what condition?	Side effects experienced:

Please remember to **notify us of any changes** during your treatment with Advanced Motion Manual Therapy.

Medication Categories:

____ Anti-Coagulant (Heparin, Coumadin/Warfarin, etc.)

_____ Aspirin

____ Immunosuppressant (Corticosteroid/Prednisone, Imuran, etc.)

CHECK ALL THE STATEMENTS THAT ARE TRUE:

_____ Changes in the way my bladder or bowels function

_____ Swelling in ankles/feet or hands

_____ Numbness or tingling in feet/legs or hands/arms

_____ Unexplainably lost or gained more than 10 pounds

_____ I have had recent internal bleeding (ulcer, intestinal, etc.)

_____ I have an implant (IUD, pacemaker, stent, other)

_____ I am pregnant or plan to become pregnant

_____ Eating changes my symptoms

_____ Blurred vision

_____ I feel dizzy

_____ I wake with night pain

_____ I have had a recent infection

Client/Guardian signature: _____ Date: _____

Print client name: _____