MUNGER
PHYSICAL THERAPY

I would like to personally thank you for choosing us to serve you for your physical therapy needs. Our team takes pride in offering a professional and friendly environment for you to rehabilitate. Our goal is to create a safe and comfortable environment for all to heal using the most up-to-date and advanced treatment techniques to provide a quick recovery.

If you have any questions in regards to physical therapy one of our licensed therapists would be happy to speak with you. Please call the front desk to arrange this. Billing questions can be addressed to Judy at (810) 385-7405.

Before your first visit there are a few things we would like you to be aware of:

- If you are coming to be evaluated for the neck or shoulders please consider a tank top or sports bra so we have access to your shoulder and neck.
- If you are coming to be evaluated for low back, hips, knees, or feet please bring loose fitting shorts (If you do not have them, we can provide them for you).
- The first visit will last about an hour and will include a thorough examination, a computer survey, and in many cases exercise to be done at home.
- A physical therapy program may last 4-6 weeks depending on you needs, so bring your calendar to set up your appointments.
- Remember your prescription for physical therapy if you have one, an updated health history form, current medication list, your insurance card and a current ID.
- Please arrive 15 minutes early.

We look forward to working with you to achieve your goals,

Markus Munger PT, Cred. MDT

Clinton Township
44925 Morley Drive
Clinton Township, MI 48036
586.846.4320

Fort Gratiot
4351 24th Ave. Suite 1
Fort Gratiot, MI 48059
810.385.7405

MUNGER
PHYSICAL THERAPY

First Name: _____ MI: _____

Last Name:_____

Address: _____ Date: _____

Home Phone: (__)_____ Work Phone: (__)_____ Cell Phone: (___)_____

SS#: _____ E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: ☐M ☐F

Marital Status: ☐S ☐M ☐D ☐W

How did you hear about us? _____

Have you had therapy before in the last year? ☐Yes ☐No: If yes, describe:_____

Have you received Home Care in the last year? ☐Yes ☐No: If yes, what was your date of discharge? _____

Emergency Contact: (___)_____ Name: _____

Reason for Therapy: _____ Date of Onset: _____

Physicians Name: _____ Last Seen: _____

Responsible Party: _____ Relationship: _____

Address: _____ City: _____ Phone: (___)_____

Employer: _____ Occupation: _____

Primary Insurance: _____ Insured Name: _____ D.O.B: _____

Group #: _____ID#: _____ Insured Employer: _____

Relationship to Insured: _____ Sex: ☐M ☐F

Secondary Insurance: _____ Insured Name: _____ D.O.B:_____

Group #: _____ ID#: _____ Insured Employer: _____

Relationship to Insured: _____ Sex: ☐M ☐F

Patient Name:_____ Date of Birth:_____

Please Initial Each as Applicable

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Munger Physical Therapy. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or contact of sensitive nature.

INITIAL:_____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

INITIAL:_____

LIABILITY: I know and agree that Munger Physical Therapy is not responsible for loss or damage to personal valuables.

INITIAL:_____

WAVIER AND RELEASE: I hereby release, discharge and acquit Munger Physical Therapy, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

INITIAL:_____

AUTHORIZATON OF PAYMENT: I hereby assign all benefits directly to Munger Physical Therapy and also authorize release of any medial records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice and Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive I will be financially responsible for payment.

INITIAL:_____

CANCELLATION POLICY: Failure to give a 24 hour notice for cancelled appointments will result in a thirty dollar fee.

INITIAL:_____

NOTICE OF PRIVACY PRACTICES: Is accessible for viewing.

INITIAL:_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Date: _____

Witness Signature _____Date: _____

Patient Name:_____ Date of Birth:_____

Do you have or have you ever had any of the following conditions? **(Check all that apply)**

[ ] **Pregnant**
[ ] **Currently Pregnant**
[ ] **Arthritis**
[ ] **Cancer**
[ ] **Visual Impairments**
[ ] **Heart Condition**
[ ] **Congestive Heart Failure**
[ ] **Heart Attack**
[ ] **Atherosclerotic Disease/CAD**
[ ] **Angioplasty**
[ ] **Valvular Disease**
[ ] **Stents**
[ ] **Arrhythmia**
[ ] **Coronary Artery Bypass Graft**
[ ] **Angina**
[ ] **Pacemaker**
[ ] **Stroke**

[ ] **High Blood Pressure**
[ ] Controlled
[ ] Uncontrolled
[ ] **Low Blood Pressure**
[ ] **Thyroid Problems**
[ ] **Diabetes**
[ ] Controlled
[ ] Uncontrolled
[ ] **Depression**
[ ] **Dizziness/Fainting**
[ ] **Fractures**
[ ] **Headaches**
[ ] **Hepatitis/HIV/AIDS**
[ ] **Kidney Problems**
[ ] **Recent Pneumonia**
[ ] **Neurological Diseases**
[ ] **Peripheral Artery Disease**

[ ] **Osteoporosis**
[ ] **Anxiety or Panic Attacks**
[ ] **Incontinence**
[ ] **Respiratory Problems**
[ ] **Asthma**
[ ] Controlled
[ ] Uncontrolled
[ ] **COPD**
[ ] Controlled
[ ] Uncontrolled
[ ] **Emphysema**
[ ] **Bronchitis**
[ ] **Seizures**
[ ] Controlled
[ ] Uncontrolled
[ ] **Back Pain**
[ ] **Allergies:**

Prior Surgeries/Dates:

_____

_____

What specific activities are you having difficulty with?

_____

_____

What are the personal goals you hope to achieve from therapy?

_____

Have you had prior physical/occupational therapy for this condition? What was done and what were the results?

_____

Patient Name: _____ Birth Date: _____ Date: _____

Name of Medication	Dosage	How Administered	When to Take	Why Take It?	Physician

***Include all prescription and over the counter medications.**

Patient Signature:_____

Reviewed By: _____