We 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 in. We are committed to utilizing the latest and most advanced treatment methods to facilitate a swift recovery.

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 shoulder, 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 you 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 functional report survey, and in many cases exercises to be done at home.**
- ☐ **A physical therapy program may last 4-6 weeks based on your need, so bring your calendar to set up appointments.**
- ☐ **Remember your prescription for your 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

Jim Achatz PT, MPT, Cred. MDT, CMP, CIDN

Fort Gratiot	**Marysville**	**Clinton Township**
4351 24th Ave. Suite 5 Fort Gratiot, MI 48059 (810) 385-7405	782 Huron Blvd Suite 4 Marysville, MI 48040 (810) 990-8612	44925 Morley Drive Clinton Township, MI 48036 (586) 846-4320

If you have any questions regarding physical therapy one of our licensed therapist would be happy to speak with you. Please call the front desk to arrange this. Any questions regarding billing can be addressed to Judy at the Fort Gratiot location.

PLEASE FILL OUT COMPLETELY

New Patient Information			
Full Legal Name:			
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell:	
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:	Phone:		
Reason for Therapy:	Surgery Date:	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		

New Patient Information

Patient Name: Date of Birth:

- ☐ 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
- ☐ Peripheral Artery Disease
- ☐ High Blood Pressure
  - ☐ Controlled
  - ☐ Uncontrolled
- ☐ Low Blood Pressure
- ☐ Currently Pregnant
- ☐ Thyroid Problems
- ☐ Diabetes
  - ☐ Controlled
  - ☐ Uncontrolled
- ☐ Depression
- ☐ Dizziness/Fainting
- ☐ Fractures
- ☐ Headaches
- ☐ Hepatitis/HIV/AIDS
- ☐ Kidney Problems
- ☐ Prior Surgeries
- ☐ Recent Pneumonia
- ☐ Neurological diseases
- ☐ Back pain
- ☐ Osteoporosis
- ☐ Anxiety or Panic Attacks
- ☐ Kidney problems
- ☐ Incontinence
- ☐ Respiratory Problems
  - ☐ Asthma
    - ☐Controlled
    - ☐Uncontrolled
  - ☐ COPD
    - ☐Controlled
    - ☐Uncontrolled
  - ☐ Emphysema
  - ☐ Bronchitis
- ☐ Seizures
  - ☐ Controlled
  - ☐ Uncontrolled
  - ☐ Allergies

If checked any above, explain: _____

_____

What specific activities are you having difficulty with? _____

_____

What are your personal goals you hope to achieve from therapy? _____

_____

_____

Have you had prior Physical/Occupational Therapy for this condition? ☐YES ☐NO

What was done, what were the results?

_____

_____

Authorization/Consent

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 direct contact of sensitive nature.

INIT: _____

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.

INIT: _____

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

INIT: _____

WAIVER 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.

INIT: _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Munger Physical Therapy and also authorize release of any medical 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.

INIT: _____

CANCELLATION NOTICE: Failure to give a 24-hour notice for a cancelled appointment will result in a no show fee.

INIT: _____

NOTICE OF PRIVACY: Is Accessible for viewing.

INIT: _____

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

Patient/Guardian Signature _____ Date: _____

Witness Signature _____ Date: _____

Medication List

Patient Name: Date of Birth:

NAME OF MEDICATION	DOSAGE	HOW ADMINISTERED	WHEN TO TAKE?	WHY TO TAKE?	PHYSICIAN

Date: _____

Include all prescription and over the counter medication

Patient Signature: _____ Reviewed by: _____

OFFICE USE

WT: HT: