Dana Kernan, PT, DPT, OCS, MTC, ATC
3819 E Indian School Rd, Phoenix, AZ 85018
KernanMPT@gmail.com
480-524-0536

Client Health History Form

Name: _________________________________

CURRENT CONDITION/COMPLAINTS

Describe your current condition/concern: ____
____
____

When did the problem start? ____________________________

What are your goals for Physical Therapy? ____

What treatments have you had in the past for this condition? ____
__________________________________ **What was helpful/not helpful**?__________________________________
____

How would you describe your general health? **Poor** **Fair** **Good** **Very Good** **Excellent**

Are your symptoms **Staying the same** **Getting better** **Getting worse**

Previous Diagnostic Testing: ☐**X-rays** ☐**CT scan** ☐**Endoscopy/Colonoscopy** ☐**MRI** ☐**Ultrasound**

Other: ____

Since the onset of your current symptoms have you had:

Y	N	Fever/Chills	Y	N	Unexplained tiredness
Y	N	Unexplained weight change	Y	N	Unexplained muscle weakness
Y	N	Dizziness or fainting	Y	N	Night pain/sweats
Y	N	Change in bowel or bladder function	Y	N	Numbness/Tingling legs or arms/hands
Y	N	Blurred vision			

Other: ____

What is your basic feeling about your health condition (e.g. fear, uncertainty, resignation, anger, hopelessness or hope, other)? ____

Average number hours of sleep/night? __________________ **Sleep aides?** __________________

MEDICAL HISTORY

Medications/Supplements: ____
____

Allergies: ____ **Do you smoke?** **Y** **N If yes, quantity/frequency:** ____________ **Method of birth control:** ___________

Diet: **Vegan** **Vegetarian** **Some meat** **Heavy meat** **Do you meditate?** **Y** **N**

Alcohol consumption: **Never** **Occasional** **Frequently**

Drug Use? _____________________

Kernan MANUAL PHYSICAL THERAPY

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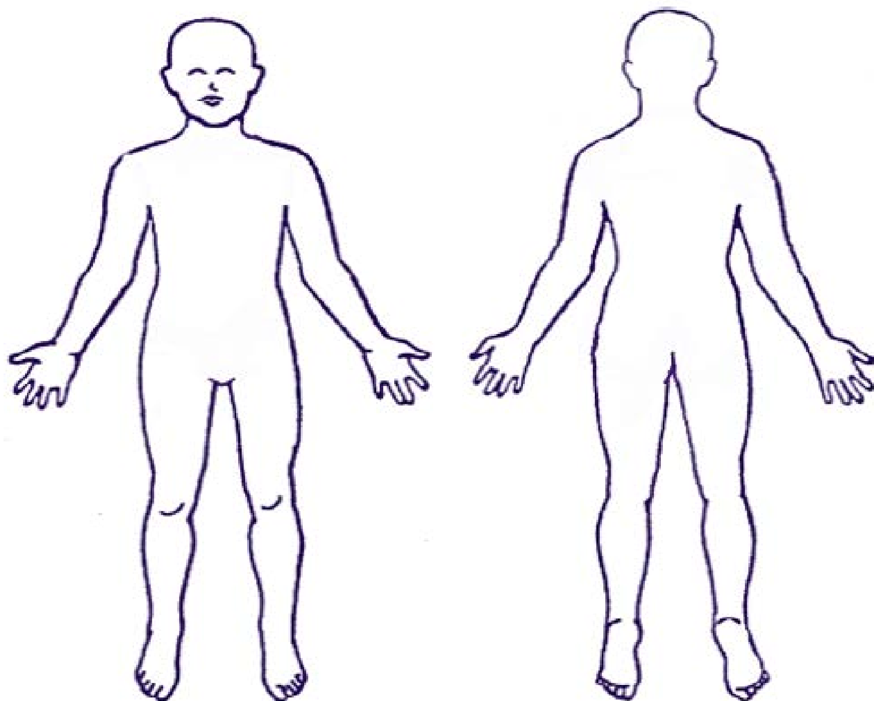
Please rate your symptoms on a scale of 0 to 10 (with 0 = no pain and 10 = need to go to emergency room)

Currently: _________/10
At Best: __________/10
At Worst: _________/10

Therapist will mark body diagram during first visit



Check ALL the words that describe your symptoms:

Numbness **Stabbing** **Burning** **Irritating** **Aching** **Throbbing** **Tender** **Unbearable**
Shooting **Sharp** **Constant** **Radiating** **Intermittent** **Other** ______________________________

Medical and Surgical History

General	Cardiovascular / Blood	Digestive
☐Headaches / Migraines	☐High Blood Pressure	☐IBS
☐Blackouts	☐Heart Attack / MI Heart Disease	☐Crohn's Disease
☐Dizziness / Vertigo	☐Cardiac Heart Failure (CHF)	☐Celiac Disease
☐Sinus Problems	☐Aneurysm	☐GERD / Gastritis
☐History of Fall(s)	☐Bleeding disorder	☐Ulcer ____________________
☐Balance Disturbances	☐Blood clots / DVT	☐Frequent Loose Stools
☐Hearing Loss	☐Anemia	☐Frequent Constipation
☐Memory Loss	☐Chest Pain / Angina	☐Discomfort after meals
☐Insomnia	☐Arrhythmia	☐Hiatal Hernia
	☐High Cholesterol	☐Swallowing Dysfunction
		☐Liver Disorder

Patient Name: ______________________ DOB: _______________

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Musculoskeletal/Orthopedic	**Immune / Endocrine / Metabolic**	**Surgical History**
☐Osteroarthritis _______________	☐Diabetes ☐Type 1 or ☐Type 2	☐CABG / Bypass Surgery
☐Fractures ___________________	☐Low Blood Sugar	☐Pacemaker / Defibrillator
☐Compression Fracture	☐Hepatitis ☐A ☐B ☐C	☐Vascular Surgery / Stents
☐Dislocation__________________	☐HIV / AIDS	☐Abdominal Surgery
☐Inguinal Hernia	☐TB	☐Gastric Bypass Surgery
☐Hernia(other)________________	☐Cancer __________________	☐Hysterectomy
☐Diastasis Recti	☐Thyroid Dysfunction	☐Tubal Ligation
☐Carpal Tunnel	☐Autoimmune Disease	☐Laparoscopy
☐Thoracic Outlet Syndrome	☐Osteoporosis / Osteopenia	☐Bladder Surgery
☐Spinal Stenosis	☐Rheumatoid Arthritis	☐C-Section
☐Sciatica	☐Gout	☐Hernia Surgery
☐Spondylolisthesis	☐Lupus	☐Gall Bladder Surgery
☐Herniate Disc	☐Fibromyalgia	☐Orthopedic Surgery
☐Annual Tear	☐Inflammatory	☐Back / Neck Surgery
☐Temporal-Mandibular Dysf	Condition_____________________	☐Plastic Surgery
☐Other Injuries _______________		☐Other Surgeries_______________
Urogenital / Gynecological	**Respiratory**	**Nervous System**
☐Urological Disorder	☐Asthma	☐Head / Brain Injury
☐Kidney Disease_______________	☐Emphysema / COPD	☐Stroke / TIA
☐Incontinence_________________	☐Pneumonia	☐MS
☐Endometriosis	☐Allergies	☐Peripheral Neuropathy
☐Dysmenorrhea	☐Sleep Apnea	☐Epilepsy / Seizure Disorder
☐Gynecological Disorder	☐Deviated Septum	☐Parkinson's Disease
☐Fibroid / Cysts	☐Shortness of Breath	☐Neuromuscular Disorder
☐# of childbirths __________	☐Other:_____________________	☐Other:_____________________
Trauma	**Nutritional**	**Other:**
☐Whiplash	☐Nutritional Deficiency	
☐Motor Vehicle Accident	☐Food Allergies	
☐Concussion	☐Eating Disorder	
☐Other Trauma		

By signing this document, I attest that all information is as true and accurate of a report of history that I am able to provide. I agree that should I remember any new information in subsequent sessions, whether I feel relevant or not, I will report it.

Client / Guardian Signature: ____________________________________Date: ____________

Print Client / Guardian Name: __________________________________

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CLIENT INFORMATION

Client Name: ___________________________________**Date:** ______________**DOB:** ____________**Age:** ____
I identify my gender as: ______________
Address:____ **City:** _____________ **State**: _____ **Zip**: ________
Primary Phone: _______________________ **home cell work**
Secondary Phone: ______________________ **home cell work Email:** ________________________
Emergency Contact:_____________________________ **Phone**:__________________ **Relation**:_____________
How do you prefer to receive communication? ☐**Text** ☐**Email** ☐**Phone**
Currently working? Yes No Occupation: _________________________
Referring Provider: _________________________ **Number:** ______________________

PRIVACY POLICY

Acknowledgment of receipt and understanding of use of your protected health information:
I consent to Kernan Manual Physical Therapy (KMPT) to the use and disclosure of my protected health information for the purpose of treatment, communication with relevant healthcare providers, obtaining payment, for day to day health care operations and for appointment reminders. I acknowledge that I have access to the detailed copy of the Notice of Privacy Practices on the KernanMPT.com website and may also request a hard copy from KMPT. KMPT has the right to make changes to its Notice of Privacy Practices, which will also be updated on the website for review.

Client/Guardian signature ____________________________________ ***Date*** _________________
By typing your name on line above, it represents your signature and acceptance of the statement(s) above.

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

Name of Individuals involved in your care to whom we may disclose information:
Name:________________________________ Relationship:______________________Number:_________
Name:________________________________ Relationship:______________________Number:_________

FINANCIAL POLICY

Kernan Manual Physical Therapy LLC (KMPT) provides physical therapy on a “pay at time of service” basis. By removing ourselves from contracted status with insurance companies, we do not have to limit the time or quality of treatment we provide because of insurance company restrictions or elevate our rates to pay for billing service. We are considered an out-of-network provider.
By signing this agreement, I understand that KMPT will not bill my insurance company and that I am entering into care as a cash-pay client. I understand that at time of service, I will receive a printed statement which I can submit to my insurance company for their consideration of reimbursement. I understand that guarantees or estimates regarding what reimbursement my plan allows cannot be made. I agree to pay KMPT 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 for all returned checks.

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NO-SHOW/CANCELLATION POLICY

I understand that if I cancel more than 24 hours in advance, I will not be charged a cancellation fee. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $75.

CONDITIONS & CONSENT FOR PHYSICAL THERAPY AT KERNAN MANUAL PHYSICAL THERAPY LLC

COLLABORATION/COOPERATION WITH TREATMENT

I understand that in order for physical therapy to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand the importance of and agree to cooperate with recommendations given and for performance in plan created with the therapist, including home physical therapy program that is created for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

NO WARRANTY

I understand that the physical therapist cannot make any promises or guarantees related to improvement in my condition. I understand that my therapist can share opinions and available study statistics regarding results of the treatment for my condition and will discuss treatment options with me before I consent to treatment.

INFORMED CONSENT FOR EVALUATION AND TREATMENT

The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy have been explained to you. The therapist provides a wide range of services. I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. In understand that I can decline any portion of the evaluation or treatment at any time.

Potential Risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition.

Potential Benefits: May include an improvement in your symptoms or an increase in your ability to manage your symptoms with an increase in ability to perform your daily activities. You may also experience improved strength, awareness, flexibility, and endurance in your movements and activities. You will gain a greater understanding of and management of your condition. You may also have greater awareness of resources available to you.

I have read the above information and agree to all aspects and I consent to physical therapy evaluation and treatment. I understand the risks, benefits, and alternatives to treatment. I hereby voluntarily consent to physical therapy evaluation and treatment. I understand that I may choose to discontinue treatment at any time.

Patient/Guardian Signature ____ ***Date*** ____________

By typing your name on line above, it represents your signature and acceptance of the statement(s) above.

FOR OFFICE USE ONLY

I hereby certify that I have reviewed this form with the patient and have explained the nature, purpose, benefits, risks of, and alternatives to purposed treatment and have offered to answer any questions and have fully answered all such questions. I believe the patient/guardian fully understands what I have explained and answered.

Physical Therapist Signature___________________________________ ***Date*** __________

Patient Name: ______________________ DOB: _______________