Center IMT™

Integrative Manual Therapy and Diagnostics

CenterIMT Philadelphia
828 Paoli Pike
West Chester, PA 19380
610-344-7210
(fax) 610-344-7292
www.CenterIMT.com
CIMTPhiladelphia@CenterIMT.com

Patient Information

Welcome to CenterIMT, and thank you for selecting our practice. In order to serve you properly, we will need the following information. All information will be kept strictly confidential.

(please print clearly)

Patient Name _____

Street Address _____

City _____ State/Prov. _____ Zip/Postal Code _____

Home Phone _____ DOB ___ /___ / ___ *(circle one)* Single Divorced Separated Widowed

Cell Phone _____ Fax _____ Email _____

If Child, Parent/Guardian's Name _____

How Did You Learn of CenterIMT _____

Employer _____ Occupation _____

Address _____ Phone _____

Referring Physician _____ Phone _____

Address _____

Family Physician _____ Phone _____

Address _____

Please check if one of the following applies:

☐ Worker's Compensation (USA) Insurance Carrier _____
Contact Name and Phone _____

☐ Medicare/Medicaid (USA) Policy Number _____

Emergency Contact (Please provide us with the name of the nearest relative **not** residing with you)

Name _____ Relationship _____ Phone _____

I understand that payment is expected on the day of each treatment, with the exception of worker's compensation insurance coverage. I am responsible for all charges, regardless of insurance coverage. I understand that CIMT is not a Medicare/Medicaid provider (USA). I understand that CIMT expects prompt payment of all bills for services rendered. I am responsible for prompt payment for all such bills.

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

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PATIENTS' RIGHTS AND RESPONSIBILITIES

PLEASE PRINT CLEARLY:

Name _____

Address _____

I, _____, am a responsible consumer. I have the following rights:

- ✓ The right for disclosure regarding costs
- ✓ The right for disclosure regarding benefits
- ✓ The right to make decisions regarding what happens to my or _____'s (client name, if other than self) BODY
- ✓ The right to question risk associated with any proposed treatment
- ✓ The right to request expected benefits of any proposed treatment
- ✓ The right to request a comparison of the benefits and risks possible both with and without any proposed treatment
- ✓ The right to request an explanation of reasonable alternatives to any proposed treatment.
- ✓ The right to access care by IMT
- ✓ The right to patient care of the highest quality
- ✓ The right for a plan of continuity of care
- ✓ The right to be involved in the goals of treatment and plan of care

I, _____, am a responsible citizen. I agree to the following:

- ✓ I will be responsible for financial reimbursement for all services rendered.
- ✓ I will recognize that I am responsible for disclosure of any and all information considered pertinent by management and clinical associates.
- ✓ I will practice acceptable behavior as accorded to me by management and clinical associates.
- ✓ I will inform management and clinical associates whenever I require any change in status regarding the above rights and privileges in a timely manner and in writing.

Signature of Client/Guardian _____ Date _____

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Notice of Privacy Practices
CenterIMT Philadelphia

Privacy Officer: Penny Zimmerman PT, ATC, IMTC

Acknowledgement of Receipt

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ **Date**: _____

Print Name: _____ **Telephone**: _____

If not signed by the patient, please indicate your relationship to the patient:

_____

For Office Use Only:

- ▫ **Signed form received by**: _____
- ▫ **Acknowledgement refused**:

  Efforts to obtain: _____

  _____

  Reasons for refusal: _____

  _____

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Authorization for Release of Records

Patient Name _____

PLEASE LIST ANY INSURANCE COMPANIES AND/OR HEALTH CARE PROVIDERS THAT YOU WOULD LIKE TO AUTHORIZE RELEASE OF YOUR MEDICAL RECORDS TO UPON THEIR REQUEST.

RECORDS RELEASE TO INSURANCE

I authorize CenterIMT to release pertinent clinical and account information to the following insurance companies to facilitate my reimbursement:

1. _____
2. _____
3. _____
4. _____
5. _____

RECORDS RELEASE TO HEALTHCARE PROVIDERS

I authorize CenterIMT to release pertinent clinical and account information to the following practitioners:

1. _____
2. _____
3. _____
4. _____
5. _____

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

If a practitioner of CenterlMT refers me to participate in Plan A (a treatment sequence of Integrative Manual Therapy, Hyperbaric Oxygen, and Endermologie), I authorize CenterlMT to release my name and information to HYPERBARIC SERVICES OF AMERICA (affiliated with CenterlMT) so they may contact me with more information

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

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CANCELLATIONS AND MISSED APPOINTMENTS

When you schedule an appointment in one of our Centers, that time is reserved especially for you. When you miss an appointment, without calling to cancel within a reasonable period of time, your practitioner does not have the opportunity to offer that time to someone else in need of services. Missed appointments can also interfere with your progress in treatment.

It is our policy that patients are responsible for all appointments they have scheduled. Patients who choose not to attend or call to cancel their appointments are still responsible for these appointment times. Therefore, the following policy will apply:

- **24 HOURS (1 WORKING DAY) NOTICE IS REQUIRED TO CANCEL EACH ONE HOUR APPOINTMENT YOU HAVE SCHEDULED.** (For example: 2 hours scheduled = 2 working days notice; 3 hours scheduled, 3 working days notice, etc.)

- **FOR ANY LATE CANCELLATION OR MISSED APPOINTMENT, THE CHARGE WILL BE 100% OF THAT VISIT'S FEE.**

Fees for missed appointments and/or late cancellations are expected at or before the patient's next scheduled appointment. Insurance does not cover these fees.

Any patient who misses more than two appointments without sufficient notice of cancellation during his or her course of treatment is subject to review and may be required to prepay for scheduled sessions.

Clients can call to check if the therapist is running on time. If the therapist is late, the patient will not lose any treatment time. When the client is late for the session, the client incurs the loss of time, and payment for the full session is expected.

Any exceptional circumstances will be submitted to our Practice Manager for review.

Patient or Guardian Signature _____ Date _____

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☐ RPT/Center IMT: (List) _____ ☐ Desert Light Health Associates

INTAKE INFORMATION

_____	_____	_____
Date	**Patient Name**	**Current Age**

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant and important. Thank you for your effort. Please print neatly.

Who recommended you to this office?_____

Official Diagnosis or Main Problem:_____

_____

Reason for visit (if different from above)_____

IMPORTANT:
To the patient: Please list below the main complaints/challenges you have in order of their importance:

1._____
2._____
3._____
4._____
5._____

☐ **RPT/CenterIMT Clients**: Which Doctor referred you to our clinic? (List Below)
Is there anyone else you would like to send this report to? (CC Below)
OR
☐ **DLHA Clients**: Your report will be addressed to "To Whom It May Concern". Is there anyone else you would like this report sent to? (List Below)

Give us their name and address:

_____
_____
_____
_____

CC: Name and address:

_____
_____
_____
_____

Updated 5-13-04

Please report all current areas of pain and the usual range of pain (0 no pain, 10 excruciating/debilitating pain).

RANGES of PAIN: (For Example √ Head 4-7)

□ Head _____	□ Right Lower Arm _____	□ Right Front Thigh _____
□ Face _____	□ Left Lower Arm _____	□ Left Front Thigh _____
□ Jaw _____	□ Right Wrist _____	□ Right Back Thigh _____
□ Front of Neck _____	□ Left Wrist _____	□ Left Back Thigh _____
□ Back of Neck _____	□ Right Fingers _____	□ Right Knee _____
□ Right Side of Neck_____	□ Left Fingers _____	□ Left Knee _____
□ Left Side of Neck _____	□ Upper Back _____	□ Right Shin _____
□ Right Shoulder _____	□ Chest/Rib Cage _____	□ Left Shin _____
□ Left Shoulder _____	□ Abdomen _____	□ Right Foot _____
□ Right Upper Arm _____	□ Low Back _____	□ Left Foot _____
□ Left Upper Arm _____	□ Buttocks _____	□ _____ _____
□ Right Elbow _____	□ Right Hip _____	□ _____ _____
□ Left Elbow _____	□ Left Hip _____	□ _____ _____

Please indicate what makes your pain worse:
___Lying Down ___Sitting ___Standing ___Walking ___Driving ___Running ___Working ___Time of Day ___Too Much Activity ___Bending ___Reaching ___Lifting ___Squatting ___Kneeling ___Too Little Activity ___ Other (Specify): _____

_____

_____

What makes your pain decrease? (Explain):
___Lying Down ___Sitting ___Standing ___Walking ___Driving ___Running ___Working ___Time of Day ___Too Much Activity ___Bending ___Reaching ___Lifting ___Squatting ___Kneeling ___Too Little Activity ___Other (Specify):_____

_____

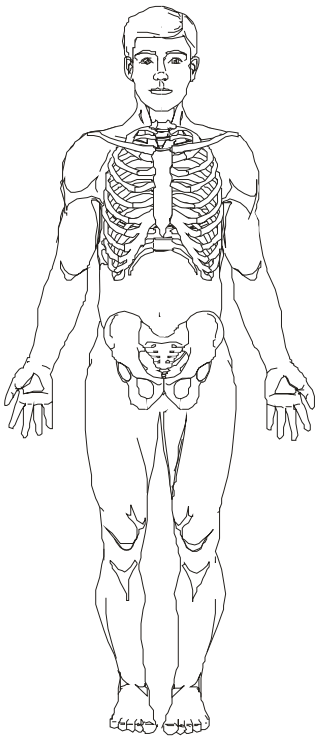
_____

When did your pain begin? (Weeks, Months, Years ago)? _____
At Birth? _____Date: _____

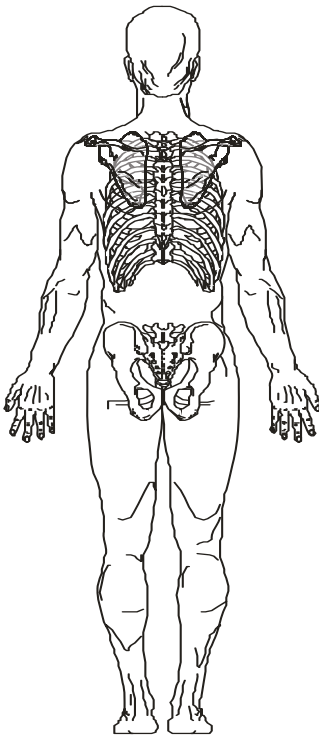
Was your onset of pain sudden? _____ Gradual? _____ Explain (if necessary):
_____

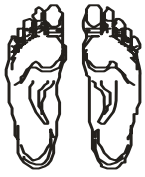
Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible.

Front



Back

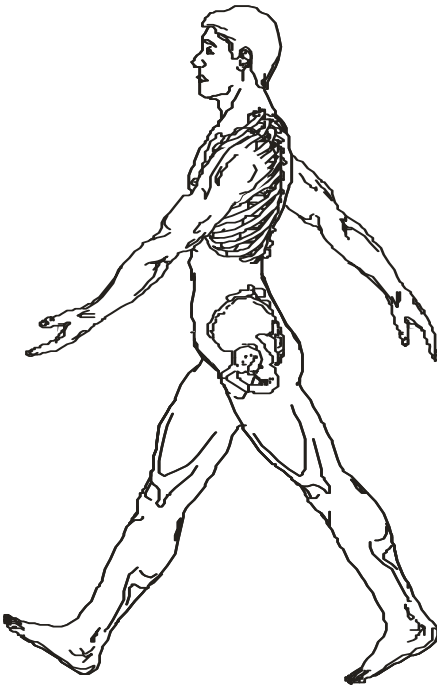




R L

Right Side

Left Side

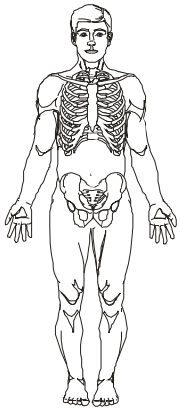


Therapist: Please put this page in the patient's chart.
Paresthesia: Please check the following areas of "funny feeling" (tingling, burning, pins and needles, etc.)

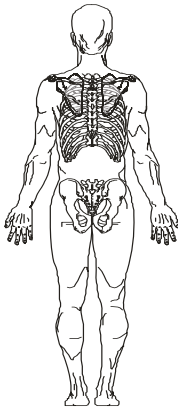
☐ Head	☐ Right Lower Arm	☐ Right Front Thigh
☐ Face	☐ Left Lower Arm	☐ Left Front Thigh
☐ Jaw	☐ Right Wrist	☐ Right Back Thigh
☐ Front of Neck	☐ Left Wrist	☐ Left Back Thigh
☐ Back of Neck	☐ Right Fingers	☐ Right Knee
☐ Right Side of Neck	☐ Left Fingers	☐ Left Knee
☐ Left Side of Neck	☐ Upper Back	☐ Right Shin
☐ Right Shoulder	☐ Chest/Rib Cage	☐ Left Shin
☐ Left Shoulder	☐ Abdomen	☐ Right Foot
☐ Right Upper Arm	☐ Low Back	☐ Left Foot
☐ Left Upper Arm	☐ Buttocks	☐ _____
☐ Right Elbow	☐ Right Hip	☐ _____
☐ Left Elbow	☐ Left Hip	☐ _____

Paresthesia Diagram: Please shade in all areas of "funny feeling" (tingling, burning, pins and needles, etc.)

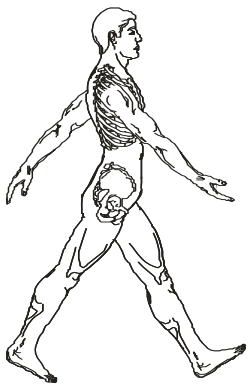
Front:



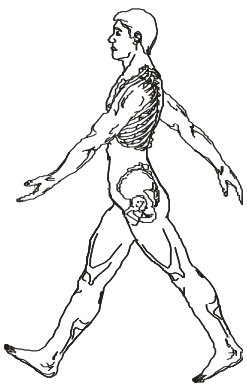
Back:



Right Side:



Left Side:



Therapist: Please place this page in the patient's chart.

Patient Name: _____

Please tell us about your symptoms by checking the appropriate areas:

	Frequency			**Severity**		
	Occasional	**Often**	**Constant**	**Mild**	**Moderate**	**Severe**
Dizziness, light-headed						
Pass out easily (faint)						
Decreased concentration/ attention						
Short term memory loss						
Slurred speech						
Balance or coordination problems						
Headaches						
Nausea						
Indigestion						
Difficulty swallowing						
Ears: ringing, stuffy, painful						
Vision: blurring, burning, aching, pressure, change, double						
Drooping eyelid or any changes in your pupils						
Allergies						
Sinus problems						
Nagging cough, hoarseness						
Chest Pain						
Cold hands						
Cold feet						
Stiffness						
Bowel problems						
Unusual bleeding or discharge						
Sexual function problems						
Change in any wart or mole						
Sore that does not heal						
Thickening in your breast/elsewhere						
Snore						
Pain wakes you from a sound sleep						
Night sweats						

Function: Activities of daily living are compromised as follows:

Bed Activities: □ Lying on stomach is □ Painful □ Difficult □ Not Possible
□ Lying on back is □ Painful □ Difficult □ Not Possible
□ Lying on right side is □ Painful □ Difficult □ Not Possible
□ Lying on left side is □ Painful □ Difficult □ Not Possible
□ Rolling over in bed is □ Painful □ Difficult □ Not Possible

Transfer Activities: □ Lying to sit is □ Painful □ Difficult □ Not Possible
□ Sit to lying is □ Painful □ Difficult □ Not Possible
□ Sit to stand is □ Painful □ Difficult □ Not Possible

Standing is: □ Painful □ Difficult □ Not Possible
Present standing tolerance: _____ min/hours

Sitting is: □ Painful □ Difficult □ Not Possible
Present sitting tolerance: _____ min/hours

Driving is: □ Painful □ Difficult □ Not Possible
Present driving tolerance: _____min/hours

Sitting in a car is: □ Painful □ Difficult □ Not Possible
Present sitting tolerance in car: _____min/hours

Walking is: □ Painful □ Difficult □ Not Possible
Present walking tolerance _____min/hours/miles

Running is: □ Painful □ Difficult □ Not Possible
Present running tolerance: _____ min/hours/miles

Work is: □ Painful □ Difficult □ Compromised □ Not Possible
Present work tolerance: _____ min/hours

Stairs are: □ Painful □ Difficult □ Not Possible

Bending and lifting activities are: □ Painful □ Difficult □ Not Possible

Reaching activities (with arms) are: □ Painful □ Difficult □ Not Possible

Sport and leisure activities are: □ Compromised □ Not Possible

□ **All activities/ADL's** are performed despite □ pain □ fatigue □ lack of energy
□ headaches

□ **Other:**_____ □ painful □ difficult

How many hours do you sleep at night? _____

How many hours per day (in 24 hours) do you spend in bed?_____

How would you consider your present level of activity? ____Poor ____Fair ___Good

Please list your present hobbies: _____
_____
_____

Work/Occupation:
Please state what you do for a living: _____

Please indicate the hours you spend at work per week: _____

Or

If you are currently not working, How long have you not worked? _____
_____

Are you not working for reasons other than your pain/problem? □ Yes □ No
If so, what reason? _____
_____

Are you a full time homemaker ? □ Yes □ No

	Before pain/disability	**After pain/disability**
Hours per week spent working at a paying job		
Hours per week spent doing household chores		
Hours per week spent doing a volunteer job		

Are you presently receiving compensation (disability insurance)? □ Yes □ No

If not, are you considering or have you applied for compensation of any kind? _____
_____

If you anticipate returning to work, when do you hope to do so? _____
_____

Please describe how your present living situation is different from the way it was before you experienced pain/disability problems: _____
_____
_____

Current Assistive Devices:

Cane	□ Yes □ No
Walker	□ Yes □ No
Manual Wheelchair	□ Yes □ No
Motorized Wheelchair	□ Yes □ No
Corrective Lenses/Glasses	□ Yes □ No
Hearing Aids	□ Yes □ No
Dentures	□ Yes □ No
Prosthetics	□ Yes □ No
Shunts	□ Yes □ No
Pacemaker	□ Yes □ No
Insulin Pump	□ Yes □ No
Baclofen Pump	□ Yes □ No
Other:	

Present Home Environment:

Stairs, no railing	□ Yes □ No
Stairs, railing	□ Yes □ No
Ramps	□ Yes □ No
Elevator	□ Yes □ No
Uneven Terrain	□ Yes □ No
Bathroom modifications	□ Yes □ No

Any other obstacles: _____

_____

Current and Past Medical History:

□ Alcoholism_____
□ Allergies_____
□ Alzheimer's Disease_____
□ Arthritis_____
□ Asthma_____
□ Attention Deficit Disorder (ADD)_____
□ Attention Deficit Hyperactivity Disorder_____
□ Autoimmune Disease_____
□ Back Pain_____
□ Bronchitis_____
□ Cancer/What Type_____
□ Carpal Tunnel Syndrome_____
□ Cerebral Palsy_____
□ Cholesterol, Elevated_____
□ Chronic Fatigue Syndrome_____
□ Circulatory Problems_____

□ Colitis_____

□ Dental Problems_____
□ Depression_____
□ Diabetes_____
□ Diverticular Disease_____
□ Drug Addiction_____
□ Eating Disorder_____
□ Epilepsy_____
□ Environmental Sensitivities_____
□ Eyes, Ears, Nose, Throat Problems_____
□ Facial Palsy_____
□ Fibromyalgia_____
□ Food Intolerance_____
□ Gastrointestinal_____
□ Genetic Disorder_____
□ Glaucoma_____
□ Gout_____
□ Headaches/Frequency:_____Duration:_____Intensity Range 0-10:_____
□ Heart Disease_____
□ High Blood Pressure_____
□ Infection, Chronic (Type)_____
□ Inflammatory Bowel Disease_____
□ Irritable Bowel Syndrome_____
□ Kidney or Bladder Disease_____
□ Learning Disabilities_____
□ Liver or Gallbladder Disease (Stones)_____
□ Lymphedema _____
□ Lymphatic Problems_____
□ Mental Illness _____
□ Mental Retardation_____
□ Migraine Headaches/Frequency:_____Duration:_____Intensity/Range 0-10:____
□ Mononucleosis_____
□ Multiple Sclerosis_____
□ Musculoskeletal Problems_____
□ Obesity_____
□ Osteoporosis_____
□ Paraplegia_____
□ Parkinsons_____
□ Phobias_____
□ Pneumonia_____
□ Quadriplegia_____
□ Respiratory Problems_____
□ Rheumatoid Arthritis_____

□ Seasonal Affective Disorder_____
□ Sexually Transmitted Disease_____
□ Sinus Problems_____
□ Skin Problems_____
□ Spina Bifida_____
□ Stroke_____
□ Thyroid Trouble_____
□ Traumatic Brain Injury (TBI)_____
□ Tuberculosis_____
□ Ulcer_____
□ Urinary Tract Infection_____
□ Varicose Veins_____
□ Other_____
□ Other_____
□ Other_____

Medical (Men):
□ Benign Prostatic Hypertrophy_____
□ Decreased Sex Drive_____
□ Infertility_____
□ Prostate Cancer_____
□ Sexually Transmitted Disease_____
□ Other_____
□ Other_____

Medical (Women):
□ Breast Cancer_____
□ Breast Surgery/Reduction/Implants_____
□ Decreased Sex Drive_____
□ Endometriosis_____
□ Fibrocystic Breasts_____
□ Fibroids/Ovarian Cysts_____
□ Infertility_____
□ Menstrual irregularities_____
□ What was the date of onset of last menses?_____
□ Pelvic Inflammatory Disease_____
□ PMS_____
□ Sexually Transmitted Disease:_____
□ Vaginal Infections_____
□ Other_____
□ Other_____

List all trauma and when it occurred (All trauma, accidents injuries are important, not just recent ones.): _____
_____
_____
_____
_____
_____

List any operations you have undergone and dates (approximately):_____
_____
_____
_____
_____
_____

List any hospitalizations and dates (approximately): _____
_____
_____
_____
_____
_____

What was your last vaccination/inoculation? _____
Did you become ill? □ Yes □ No

When have you traveled out of the country? _____
Did this require inoculation? □ Yes □ No
Did you become ill? □ Yes □ No

Are you losing weight without trying? □ Yes □ No

Are you coughing up blood or noticing it in your stool or urine? □ Yes □ No

Have you lost consciousness or had double vision recently? □ Yes □ No

Family Health History:

□ Alcoholism_____
□ Alzheimer's Disease_____
□ Arthritis_____
□ Asthma_____
□ Cancer_____
□ Depression_____
□ Diabetes_____
□ Drug Addiction_____
□ Eating Disorder_____
□ Genetic Disorder_____
□ Glaucoma_____
□ Heart Disease_____
□ High Blood Pressure_____
□ Infertility_____
□ Learning Disabilities_____
□ Mental Illness_____
□ Mental Retardation_____
□ Migraine Headaches_____
□ Neurological Disorders (Parkinson's, Paralysis)_____
□ Obesity_____
□ Osteoporosis_____
□ Rheumatoid Arthritis_____
□ Stroke_____
□ Other_____
□ Other_____

Health Habits:

□ Tobacco: Cigarettes #/day ____ Cigars #/day ____ Pipe ____ Chewing ____
□ Alcohol: Wine or beer #glasses/day or week _____Liquor # ounces/day or week ____
□ Caffeine: Coffee: #6 oz cups/day _____ Tea: #6 oz cups/day _____
□ Soda w/caffeine: # cans/day _____ □ Diet Sodas #cans/day _____
□ Other:_____

Exercise: (**Check all that apply**)

□ 5-7 days per week
□ 3-4 days per week
□ 1-2 days per week
□ Infrequent
□ Never
□ 45 minutes or more duration per workout
□ 30-45 minutes duration per workout
□ Less than 30 minutes

□ Walk
□ Swim
□ Run, Jog, Jump Rope
□ Box
□ Yoga
□ Other:_____
□ Other:_____

□ Swim

Nutrition and Diet:

□ Vegetarian
□ Vegan
□ High Protein
□ Salt Restriction
□ Low Fat Diet
□ Starch/Carbohydrate Restriction
□ The Zone Diet
□ Atkins Diet
□ Other: _____
□ Other: _____

Specific Food Restrictions:

□ Dairy □ Eggs □ Soy □ Corn □ All Gluten □ Wheat □ Sugar
□ Other: _____

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest):
1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):
_____

_____

_____

List any prescribed, over the counter medications and/or supplements you are taking.

Name of those presently taking	Dosage	For how long?	List any Medications/ Supplements you have Taken during the past 5 Years:

□ Attach a piece of paper if needed.

Are you seeing any doctors or health care professionals now for any reason? (Note: These practitioners will not be contacted without your permission. Do you want us to send our evaluation note to these practitioners? □ Yes □ No

Practitioner's Name	Type of Practitioner:	Phone Number or Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____

While you are a patient here at Center IMT/DLHA a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind. "**Patient Centered Goals**" will serve as the basis for treatment. Goals will be revised as needed.

Please fill in the following so the therapist can consider your desires/goals.
The following examples are provided to assist you to answer.
I know I will be better when I can:
Example 1. Walk independently for 15 minutes with no pain.
Example 2. Work using just a splint for a half day with occasional pain.
Example 3. Sit with the help of only one person for 30 seconds.
Example 4. Play 18 holes of golf without pain in my back.

Please fill in the chart below, answering "I know I will be better when I can:

1. _____

2. _____

3. _____

4. _____

5. _____