29377 Rancho California Rd #100
Temecula, CA 92591
(951) 296-0400

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Email Address:			
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone: ( ) -		

Chose Clinic Because/ Referred to Clinic by Dr.: __________________ ☐ Insurance Plan ☐ Word of Mouth:

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Phone: ( ) -
Regular Dr./PCP	Phone: ( ) -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:		
Subscriber's Name (If different from patient):		Birth Date: / /
Policy #:	Group #:	Policy Holder's SSN:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth Date: / /
Policy #:	Group #	
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

AUTO OR WORK INJURY CLAIM (IF APPLICABLE)

Insurance Name: ☐ Auto:	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

IN CASE OF EMERGENCY

Name of Local Relative or Friend:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s). Additionally, I authorize my insurance benefits be paid directly to Mangan Physical Therapy. I understand that I am financially responsible for any remaining balance. I also authorize Mangan Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

MANGAN PHYSICAL THERAPY
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PAST MEDICAL HISTORY FORM

Patient Name ____________________

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
Other:		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ 5+ x Week	☐ Heavy Labor			
	☐ Other			

What types of exercise do you perform? ____________________

What things cause stress in your life?

Are you taking any seizure medication? ☐ Yes ☐ No If yes list name: ____________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
☐ Yes ☐ No If yes list name: ____________________

List all medications you are currently taking: ____________________

List all surgeries (including dates): ____________________

Are you pregnant? ☐ Yes ☐ No What week? ________

Is this injury related to work? ☐ Yes ☐ No If yes list body part and date.: ____________________

Is this injury related to auto accidents? ☐ Yes ☐ No If yes list body part and date.: ____________________

____________________ ____________________
Signature of Patient, Parent, Guardian, Personal Representative Date

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PAIN GRAPH

PLEASE INDICATE ON THE BODY GRAPH WHERE YOU HAVE PAIN AND HOW MUCH PAIN ON A 0-10 SCALE.

10 WORST PAIN POSSIBLE

9 EXCRUCIATING

8

7 SEVERE

6

5 MODERATE

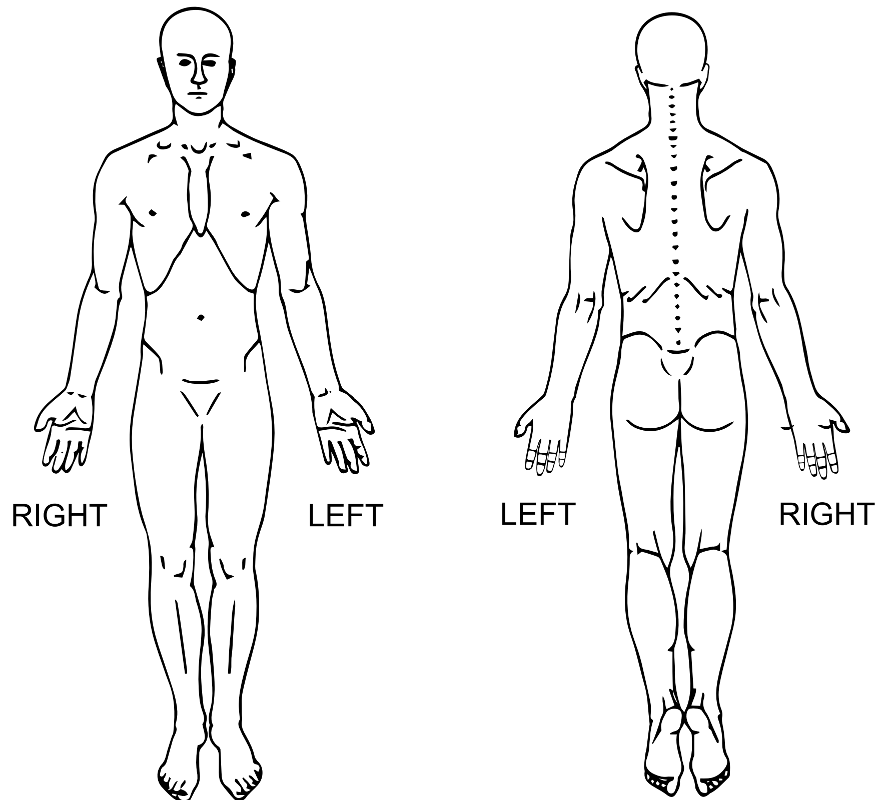
4

3 MILD

2

1 SLIGHT

0 NO PAIN



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Acknowledgment Of Receipt Of Notice Of Privacy Practices And Treatment Consent

My signature below indicates that I have been given the Notice Of Privacy Practices And Treatment Consent for Mangan Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain health care operations or as permitted or required by law I must give my written authorization to Mangan Physical Therapy to release any of my protected health care information.

I acknowledge giving consent to treatment at Mangan Physical Therapy.

____

Patient or Authorized Representative's Printed Name & Date

____

Patient or Authorized Representative's Signature

24 Hour Appointment Cancellation Policy

Mangan Physical Therapy has a 24 hour cancellation / rescheduling policy.
If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you may be charged $30.
This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.
By signing below, you acknowledge that you have read and understand the Mangan Physical Therapy policy as described above.
Thank you for your understanding and cooperation.

____

Printed Name

____

Signature