Movement | Manual Therapy | Motivation

Mobile/Concierge Physical Therapy and Wellness

Meeting you where you are to get you where you want to be!

Phone: (318) 512-1887   Email: michael@m3physio.com

Client Information

Name: ____ DOB: _____________

Address:_____________________________ City: ___________ State: ___ Zip Code: _______

Phone: __________ (Can we send texts - Y/N) Email: ________________________________

Emergency Contact: ____________________ Relationship: ___________ Phone: ____________

How did you hear about M3 Physio: ____

Consent

I understand that physical therapy, like all medical disciplines, cannot guarantee specific outcomes. Despite M3 Physio's commitment to client-centered, evidence-based care, individual responses vary. I acknowledge my right to ask questions and stop treatment at any time. I hereby consent to a physical therapy evaluation/treatment or wellness session, as jointly agreed upon by me and my physical therapist. _____ (Please initial here)

Financial Responsibility

M3 Physio operates on a self-pay basis, meaning we do not accept health insurance. Payment is due at the time of service. We accept cash, check (made payable to M3 Physio), credit/debit cards, HSA/FSA cards, and Venmo (@m3physio). Clinic sessions start at $100 for 30 minutes, prorated for longer durations, while mobile appointments incur additional fees. _____ (Please initial here)

Cancellation Policy

M3 Physio prioritizes timely care and operates on a one-on-one schedule. To ensure availability for all clients, we kindly request at least 24 hours' notice for any cancellations. This allows us to accommodate others who may want to be seen. Late cancellations (within 24 hours) or no-shows will incur a full session fee, payable before your next appointment. Exceptions may be made in case of emergencies. Clients with more than 2 cancellations without valid reason or 1 no-show may have their remaining appointments re-scheduled or terminated at the therapist's discretion. _____ (Please initial here)

Medical Release

I authorize M3 Physio to request my personal health information from authorized healthcare providers to help coordinate my best possible care. _____ (Please initial here)

I authorize M3 Physio to release my personal health information to:______________________________

____

Photo/Video Release

I give M3 Physio permission to take and use photos/videos as needed for my care. _____ (Please initial here) and to use these photos/videos for promotional purposes. _____ (Please initial here).

Current Concerns

Briefly describe your current health concern, including the onset of symptoms and any suspected cause:______________

Are your symptoms improving, staying the same, or getting worse (please circle one)

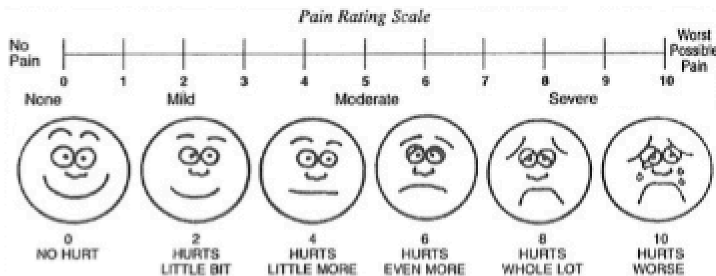
Physical activity could make my pain worse (yes/no)

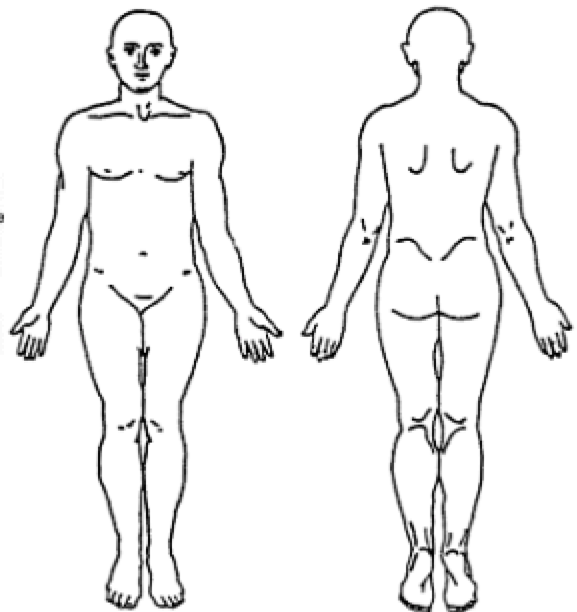
List up to 3 daily activities you are limited in doing: ______________

Describe any current stress you are experiencing:______________

Provide a brief summary of any prior treatments or diagnostic procedures relevant to your current concern:______________

Please indicate your pain level(s) on the scale and describe the location on the body chart below:





Medical History

Please describe any past surgeries and injuries: ____

____

____

Current medications/supplements: ____

____

____

Height: _______ Weight: _______

Have you ever been told you have:

- ❑ Alzheimer's/Dementia
- ❑ Anemia
- ❑ Asthma
- ❑ Cancer
- ❑ Cauda Equina Syndrome
- ❑ Cerebral Vascular Accident (Stroke)
- ❑ COPD
- ❑ Current Infection: _____________________
- ❑ Diabetes Type 1
- ❑ Diabetes Type 2
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Fracture or Suspected Fracture
- ❑ Heart Disease
- ❑ Hernia
- ❑ High Blood Pressure
- ❑ Huntington's
- ❑ Immunosuppression
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lupus
- ❑ Muscular Dystrophy
- ❑ Neuropathy
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Osteopenia/Osteoporosis
- ❑ Parkinson's Disease
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Scoliosis
- ❑ Sexually Transmitted Disease
- ❑ Thyroid Disease
- ❑ Traumatic Brain Injury
- ❑ Other: _____________________

Do you have a history of:

- ❑ Allergies
- ❑ Blood clots
- ❑ Lengthy medication treatment
- ❑ Seizures
- ❑ Ulcers
- ❑ Varicose veins

Do you have a pacemaker/defibrillator: Y/N

In the past 3 months have you had or are you experiencing:

- ❑ A change in your health
- ❑ Loss of balance/ falls
- ❑ Nausea/vomiting
- ❑ Fever/chills/sweats
- ❑ Unexplained weight loss
- ❑ Numbness or tingling
- ❑ Changes in appetite
- ❑ Difficulty swallowing
- ❑ Changes in bowel/bladder function
- ❑ Shortness of breath
- ❑ Dizziness
- ❑ Upper respiratory infection
- ❑ Urinary tract infection
- ❑ Difficulty sleeping
- ❑ Swelling
- ❑ Weakness
- ❑ Confusion/memory loss
- ❑ Fatigue
- ❑ Heartburn/indigestion
- ❑ Headaches
- ❑ Angina/Chest Pain

Do you:

- ❑ Sleep >7 hours per night
- ❑ Regularly eat healthy (protein, vegetables, fruit)
- ❑ Exercise regularly (at least 150 minutes of aerobic and 2 or more strength training days per week)
- ❑ Drink alcohol (>2 drinks per day)
- ❑ Smoke tobacco
- ❑ Use illicit drugs

Are you currently:

- ❑ Depressed
- ❑ Under stress
- ❑ Pregnant

Do you have a problem with (circle all that apply)?

- Hearing, vision, speech, communication

How do you learn best (circle all that apply)?

- Seeing, hearing, performing

Hand Preference: R/L

Have you been exposed/tested positive in the last 10 days or are you experiencing any symptoms (ex. fever, cough, sore throat, etc) of COVID-19: Y/N

Please explain any of the above answers: ____

____

____

Client signature/Print name: ______________________________________ Date: _______________

Therapist signature: ______________________________________ Date: _______________