ELEMENT
wellness & sports rehabilitation

5331 SW Macadam Ave, Ste 105, Portland, OR 97239
T {503} 445 7999 F {503} 445 7997
ElementWellnessPDX.com

Confidential New Patient Registration

Patient Information

Last Name_____ First Name_____ MI_____
Address_____ City_____ State_____ Zip_____
Home#_____ Cell#_____
Email_____ Appointment reminders: email or text? Cell carrier _____
Date of Birth_____ Age_____ Sex M / F Marital Status S /M/ D/ W
Employer_____ Occupation_____ Work# _____
Work Address_____ City_____ State_____ Zip_____
Spouse's/Partner's Name_____ Date of Birth _____
Employer_____ Work#_____
Emergency Contact_____ Phone#_____
Type of Insurance: Auto Personal Injury Private Ins Workers' Comp None
Primary Care Physician_____
Whom may we thank for referring you? _____
Reason for visit_____

Private Health Insurance Information

Insured's Name_____ Date of Birth_____
Patient's Relationship to Insured Self Spouse/Partner Child
Name of Insurance Company_____
Address_____
Phone#_____ ID#_____ Group#_____
Secondary Insurance Insured's Name_____ Date of Birth_____
Name of Insurance Company_____
Address_____
Phone#_____ ID#_____ Group#_____

Auto Injury / Personal Injury / Work Injury Information

Insurance Type Auto / Personal / Work Injury Date of Injury_____
Patient's Relationship to Insured Self / Partner/Spouse / Child
Describe how injury happened_____
_____
Name of Insurance Company_____ Phone#_____
Address_____
Adjuster Name_____ Phone#_____
Claim#_____ Policy#_____
Name of Attorney_____ Phone #_____
Were you working at the time of the accident (driving during work duty)? Y / N
Dates lost from work as a result from this accident_____
If auto injury, were you the Driver / Passenger / Pedestrian / Cyclist
Was your vehicle Rear Ended / Hit from Side R / L / Head on
# of People in your vehicle_____ Were they Injured? Y / N

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Office Policies

Element Wellness & Sports Rehabilitation welcomes you as a new patient. If you have any questions regarding our office policies, please ask any of our front desk staff for clarification prior to initialing.
Please initial each of the following:

_____**Cancellation Policy:** We require 24-hour notice for cancellations and rescheduling of appointments. If your appointment falls on a Monday or after a holiday, you must cancel the business day prior. **Cancellations must be made in person or by phone call, not through email.** If you fail to cancel 24 hours prior to the appointment, a charge of $60 will be assessed to you. This charge is due before your next visit and cannot be billed to your insurance company. You will be personally responsible for the fee. Should you choose to take advantage of our package pricing on physical therapy, you will forfeit a full visit from your package. If three appointments are cancelled without 24-hour notice, your care is subject to termination.

_____**Change of Insurance:** Please alert us right away if your insurance changes so that we can confirm your benefits.

_____**Collection Policy:** We charge 3% monthly interest for all unpaid balances over 90 days. If an account is over six months in arrears, it will be subject to legal collection. The key to avoid this situation is communication. WE WILL WORK WITH YOU! Just talk to us. If an account is placed for collection a fee of 40% will be added to the account. In addition, you may be liable for attorney fees.

_____**Motor Vehicle Accidents & Workplace Injuries:** Please notify us if you are in an accident. We will gladly bill your Personal Injury Protection or Workers' Compensation.

_____**Insurance Maximums:** Should you need treatment beyond your insurance carrier's annual maximum coverage, we will gladly continue to work with you at our "pay at time of service rates".

_____**Returned Check Policy:** Element Wellness & Sports Rehabilitation has a $35 fee for all returned checks.

_____**Please notify us** as soon as possible when your address and/or phone number changes.

_____**Childcare Policy:** We do not offer childcare in this clinic. We do provide toys in the waiting area and you are welcome to bring your child/children in the treatment room as you see fit. Please do not leave children unattended.

_____**Cell Phones: For the comfort of our patients, we prohibit cell phone conversations in the clinic. Please take all calls to the hallway and turn off all cell phones before entering the treatment rooms.**

_____**HIPAA Notice of Privacy Practices: We are required by law to maintain the privacy of, and provide individuals with, our HIPAA Notice of Privacy Practices. By initialing, you acknowledge that you have been informed of and given the right to review and secure a copy of this notice.**

Please verify that you understand all of our office policies by signing and dating below.

_____
Printed Name of Patient

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date

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Informed Consent to Chiropractic Treatment

I, _____ _____, hereby request and consent to the
(Name of Patient) (Date of Birth)
performance of the chiropractic adjustment and other chiropractic procedures, including examination tests, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by Dr. Noah Goodwill, D.C. and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Dr. Noah Goodwill, D.C.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. While these complications are very rare, soreness may be the only complication following a treatment. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the fact then known, and are in my best interest.

I have had an opportunity to discuss with Dr. Noah Goodwill, D.C., and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have, myself decided that is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date

_____ _____
Translated By Date

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Consent to Use and Disclose Protected Health Information for Treatment, Payment or Healthcare Operation Form

I _____ _____ understand that as a part of my healthcare,
(Name of Patient) (Date of Birth)

Element Wellness & Sports Rehabilitation originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and history, public health and home health, as well as any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnoses and referral information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment and healthcare operations. Element Wellness & Sports Rehabilitation is not required to agree to the restrictions requested.

This consent remains in effect unless I give written notice to revoke. I understand that my refusal to give permission will not influence the services I received.

I wish to have the following restriction to the use and disclosure of my health information:

_____

_____

_____

_____

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date

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MVC Intake Form

Name: _____ Date: _____

Mechanism of Injury

Date of the motor vehicle collision: _____ Time of collision: _____

Driver or passenger of the vehicle? □ Driver □ Passenger Are you the owner of the vehicle? □ Yes □ No

Please describe the motor vehicle collision in your own words (including street names):

_____

_____

_____

Which segment of your vehicle was impacted at the moment of impact?

□ Head-on
□ Driver side (front segment)
□ Driver side (middle segment)
□ Driver side (rear segment)
□ Passenger side (front segment)
□ Passenger side (middle segment)
□ Passenger side (rear segment)
□ Rear-end

Was the vehicle displaced? □ Yes □ No If yes, approximately how far? _____

Did the airbags deploy? □ Yes □ No

What were the road conditions? □ Dry □ Wet □ Snow-covered □ Ice-covered □ Patchy ice/snow

Was your visibility **compromised**? □ Yes □ No If yes, how? _____

Number of motor vehicles involved in the collision: _____ Total number of people involved: _____

Year, make & model of **YOUR** vehicle: _____

Year, make & model of the **OTHER** vehicle: _____

What **seat of the vehicle** were **YOU** in at the moment of impact?

□ Driver seat
□ Front passenger
□ Middle row (driver side)
□ Middle row (middle seat)
□ Middle row (passenger side)
□ Back row (driver side)
□ Back row (middle seat)
□ Back row (passenger side)
□ Other: _____

Damage to **YOUR** vehicle: □ Mild ($0-$500) □ Moderate ($501-$2000) □ Severe (>$2001) □ Totaled

Approximate speed of **YOUR** vehicle at moment of impact (M.P.H.): _____

Approximate speed of the **OTHER** vehicle at moment of impact (M.P.H.): _____

What was **YOUR** vehicle doing at moment of impact?

□ Was stopped
□ Was backing up
□ Movement unknown
□ Was moving forward
□ Was turning left
□ Was turning right

What was the **OTHER** vehicle doing at moment of impact?

□ Was stopped
□ Was backing up
□ Movement unknown
□ Was moving forward
□ Was turning left
□ Was turning right

Was **YOUR** vehicle towed from the scene of the collision? □ Yes □ No

At the **moment of impact** you were: □ Unaware □ Aware but not braced □ Aware and braced for impact

Were you wearing a seatbelt at the moment of impact? □ No □ Yes, lap belt & shoulder harness □ Yes, lap belt only

What was the position of your **head/neck** at the moment of impact?

□ Facing straight forward □ Tilted upward □ Turned right
□ Tilted downward □ Turned left □ Other: _____

What was the position of the headrest? □ at back of head □ at back of neck □ no headrest

Did your head hit the headrest during the collision? □ Yes □ No

What was the position of your body at the moment of impact?

□ Facing forward □ Turned left □ Reclined □ Leaning left
□ Turned right □ Bent forward □ Leaning right □ Other: _____

Did your body make contact with anything in the vehicle (glass, door, windshield, etc.)? □ Yes □ No

If yes, what part of the vehicle did you make contact with? _____

What was your **immediate response** after the motor vehicle collision?

□ Disoriented/dazed □ Felt tightness/stiffness □ Shock □ Other: _____
□ Felt physical discomfort □ Loss of consciousness □ Was shaken up but could think clearly _____
□ Felt immediate pain □ Frightened □ No adverse effects _____

Police Report

Were there any witnesses of the collision? □ Yes □ No Were photos taken of the damage? □ Yes □ No

Did the police show up at the scene? □ Yes □ No Was there a police report filed? □ Yes □ No

---

Medical Attention

Did you receive emergency medical attention (EMS) at the scene of the collision? □ Yes □ No

If yes, please describe: _____

_____

_____

Have you received medical attention **since the collision**? □ Yes □ No

If yes, what treatment was given? _____

What diagnosis was given? _____

Was medication prescribed? □ Yes □ No If yes, please specify: _____

How many times have you been seen since collision? _____ Date of last treatment? _____

Were x-rays taken? □ Yes □ No If yes, which region(s) was x-rayed?

_____

_____

_____

Current Symptoms:

Check **ALL** the symptoms that have become apparent **SINCE THIS COLLISION** (if no symptoms, check "None").

□ Anxiety	□ Loss of smell	□ Fever	□ Muscle soreness/tightness
□ Nervousness	□ Double vision	□ Nausea	□ Neck soreness/tightness
□ Irritability	□ Blurred vision	□ Vomiting	□ Upper back stiffness
□ Depression	□ Other visual disturbances	□ Diarrhea	□ Lower back stiffness
□ Fatigue	□ Sensitivity to light	□ Constipation	□ Upper extremity stiffness
□ Feeling faint	□ Pain behind the eyes	□ Abdominal pain	□ Lower extremity stiffness
□ Forgetfulness	□ Ringing/buzzing in ears	□ Pelvic pain	□ Right arm numbness/tingling
□ Confusion/disorientation	□ Sensitivity to sound	□ Gluteal pain	□ Left arm numbness/tingling
□ Dizziness	□ Loss of hearing	□ Genital pain	□ Right leg numbness/tingling
□ Epilepsy	□ Ear pain	□ Chest pain	□ Left leg numbness/tingling
□ Difficulty sleeping	□ Headaches	□ Throat pain	□ Pain between shoulder blades
□ Loss of taste	□ Stress	□ Shortness of breath	□ None
□ Muscular incoordination	□ Cold sweats	□ Muscle spasm	□ Other: _____

Do your symptoms **radiate** elsewhere? □ No □ Yes: _____

Did your symptoms begin **gradually or suddenly**? _____

Have your symptoms gotten **better/worse/remained the same**? _____

Are your symptoms **worse** in the: □ AM □ PM □ Unchanged by time of day

What **type** of pain/discomfort do you have?

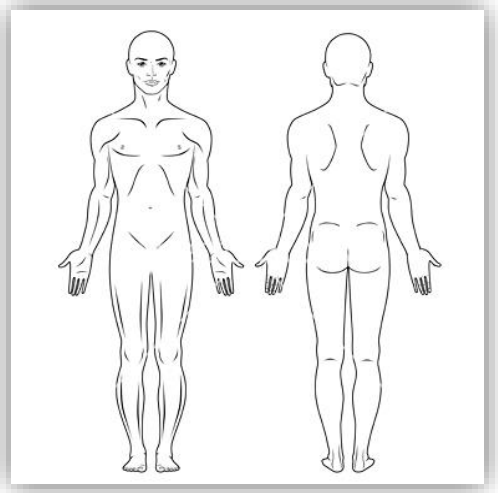
□ pain □ numbness □ tingling □ stiffness
□ soreness □ swelling □ weakness

How would you **describe** the pain/discomfort that you have?

□ burning □ dull □ throbbing □ superficial □ "pins & needles"
□ shooting □ stinging □ tingling □ deep □ uncomfortable
□ aching □ sharp □ intense □ numb

How **often** do you experience your symptoms?

□ Occasionally (0-25%) □ Intermittently (26-50%) □ Frequently (51-75%) □ Constantly (76-100%)



Indicate where you experience your symptoms.

Please rate the **intensity** of your **main area** (Specify here: _____) of pain/discomfort at each state.

WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10
	|----------Mild----------|				|----------Moderate----------|			|----------Severe----------|	

Please rate the **intensity** of your **second area** (Specify here: _____) of pain/discomfort at each state.

WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10
	|----------Mild----------|				|----------Moderate----------|			|----------Severe----------|	

Please rate the **intensity** of your **third area** (Specify here: _____**)** of pain/discomfort at each state.

WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10
	|----------Mild----------|				|----------Moderate----------|			|----------Severe----------|	

How do your symptoms affect your **ability to perform daily activities**?

□ No effect □ Moderate effect (interferes) □ Severe effect (no activity possible)
□ Mild effect (forgotten with activity) □ Limiting effect (prevents full activity)

Which activities make your symptoms **worse**?

□ No activities are painful
□ Inactivity
□ Standing for more than 10 min.
□ Standing for more than 60 min.
□ Walking short distances
□ Getting in/out of car
□ Bending forward
□ Putting on clothes
□ Putting on shoes
□ Coughing/sneezing
□ Home activities
□ Standing up/sitting down
□ Lying on stomach
□ Lying on side
□ Lying on back
□ Sleeping
□ Sexual activity
□ Sitting
□ Looking backwards
□ Going up/down stairs
□ Work activities
□ Reaching
□ Stooping
□ Kneeling
□ Balancing
□ Gripping
□ Pulling
□ Pushing
□ Squatting
□ Lifting arms overhead
□ Turning over in bed
□ Changing directions quickly
□ Running
□ Bicycling
□ Lifting heavy objects
□ Lifting light objects
□ Sports
□ Other: _____

Which activities make your symptoms **better**?

□ Ice
□ Heat
□ Muscle relaxer
□ Pain medication
□ Hot shower/bath
□ Brace/support/tape
□ Rest
□ Sleep
□ Inactivity
□ Lying on back
□ Lying on stomach
□ Activity/movement
□ Exercise
□ Foam rolling
□ Stretching
□ Acupuncture
□ Massage therapy
□ Chiropractic
□ Physical therapy
□ Nothing

Prior to the collision, were you experiencing symptoms of any kind? □ Yes □ No
If yes, please describe:

_____

_____

In the **past**, have you ever experience the symptoms you are currently experiencing? □ Yes □ No
If yes, how did these previous symptoms occur?

_____

Review of Systems:

Please check **all of the symptoms** that you are **CURRENTLY** experiencing. If none apply, check "None".

CONSTITUTIONAL SYMPTOMS:

□ General fatigue
□ Fever
□ Malaise
□ Headaches
□ Unintentional weight loss
□ Loss of appetite
□ Loss of sleep (due to pain)
□ Loss of coordination/balance
□ Dizziness
□ Night sweats
□ Chills
□ None

EYES:

□ Blurred vision
□ Pain behind the eyes
□ Crossed eyes
□ Dry eyes
□ Double vision
□ Nystagmus (involuntary eye movement)
□ Loss of vision
□ Poor vision at night
□ None

EARS/NOSE/THROAT:

□ Difficulty swallowing
□ Bleeding gums
□ Ear discharge
□ Loss of hearing
□ Hoarseness
□ Hay fever
□ Nosebleeds
□ Persistent cough
□ Ringing in ears
□ Sinus problems
□ Earache/infection
□ Chronic sinusitis
□ None

RESPIRATORY:

□ Difficulty breathing
□ Asthma
□ Bronchitis
□ Coughing up blood
□ None

CARDIOVASCULAR:

□ High blood pressure
□ Low blood pressure
□ Heart attack
□ Chest pains
□ Angina
□ Stroke
□ Deep vein thrombosis
□ Poor circulation
□ Irregular heartbeat
□ Rapid heartbeat
□ Swollen ankles/feet
□ Varicose veins
□ None

GASTROINTESTINAL:

□ Bloating
□ Constipation
□ Diarrhea
□ Vomiting
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Vomiting blood
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Ulcer
□ Stomach pain
□ Heartburn
□ Abdominal pain
□ Hepatitis
□ None

GENITOURINARY:

□ Difficulty urinating
□ Kidney stones
□ Painful urination
□ Lack of bladder control
□ Blood in urine
□ Bladder infection
□ Frequent urination
□ Kidney disorder
□ None

MUSCULOSKELETAL:

□ Neck pain
□ Jaw pain
□ Shoulder pain
□ Arm/elbow pain
□ Upper back pain
□ Mid back pain
□ Low back pain
□ Wrist/hand pain
□ Hip/upper leg pain
□ Knee/lower leg pain
□ Ankle/foot pain
□ Joint swelling/stiffness
□ Osteoarthritis
□ Muscle fatigue
□ Muscle spasm
□ None

SKIN:

□ Changes in mole(s)
□ Hives
□ Rashes
□ Itching
□ Scars
□ Eczema
□ Sores that don't heal
□ Bruises
□ None

BLOOD/LYMPH:

□ Diabetes Type I
□ Diabetes Type II
□ HIV/AIDS
□ Rheumatoid arthritis
□ Autoimmune disease
□ Cancer
□ Tumor
□ Systemic lupus
□ None

ALLERGIES:

□ Corn
□ Dairy
□ Eggs
□ Gluten/wheat
□ Soy
□ Shellfish
□ Nuts
□ Pollen/dust
□ Grass
□ Dander
□ Penicillin
□ Latex
□ None
□ Other: _____

MALES ONLY:

□ Erection difficulty
□ Lump in testicles
□ Penis discharge
□ Prostate problems
□ Sore on penis
□ Painful urination
□ Breast lump
□ None
□ Other: _____

FEMALES ONLY:

□ Breast lump
□ Breast discharge
□ Vaginal discharge
□ Bleeding between periods
□ Extreme menstrual pain
□ Hormonal replacement
□ Abnormal Pap smear
□ Abnormal menses
□ Menopause
□ Contraception use
□ Hot flashes
□ Painful intercourse
□ Pregnancy
□ Urinary incontinence
□ None
□ Other: _____
_____
_____

Occupational History:

What is your **current** job occupation? _____

How long have you worked at this job? _____

How many **weekly hours** do you currently work?_____

How would you describe your work activity level?

□ Sedentary □ Light □ Moderate □ Heavy □ Very heavy

Have you missed work due to pain/discomfort? □ Yes □ No If yes, how long? _____

Wellness History:

What is your current weight? _____ What is your current height? _____

Do you have a primary care physician? □ Yes □ No When was your **last** physical exam?_____

What kind of **exercise** do you participate in (check all that apply)?

□ Walking
□ Running
□ Aerobic classes
□ Cross Fit
□ Bicycling
□ Free weights
□ Martial arts
□ Dancing
□ Plyometrics
□ Pilates
□ Spinning classes
□ Yoga
□ Rowing
□ Swimming
□ Basketball
□ Baseball
□ Soccer
□ Hockey
□ Football
□ Tennis
□ Golf
□ Rock climbing
□ TRX Suspension
□ Calisthenics
□ Nautilus
□ None
□ Other: _____
_____

How many times per week do you exercise? _____

Do you smoke? □ Yes □ No If yes, how many packs **per day**? _____
Do you consume alcohol? □ Yes □ No If yes, how many drinks **per week**? _____
How many hours of sleep do you currently get **per night** on average? _____
Do you consider your diet healthy? □ Yes □ No If no, why? _____

Personal Health History:

Please check **all the symptoms** that you have had **in the past**.

□ Headaches
□ Jaw pain
□ Neck pain
□ Upper back pain
□ Mid back pain
□ Low back pain
□ Low back stiffness
□ Chest pains
□ Shoulder pain
□ Arm/elbow pain
□ Wrist pain
□ Hand pain
□ Hip/upper leg pain
□ Ankle/foot pain
□ Leg numbness/tingling
□ Joint swelling/stiffness
□ Visual disturbances
□ Kidney disorders
□ Ulcer
□ Diabetes
□ Chronic sinusitis
□ Constipation
□ Depression
□ HIV/AIDS
□ Dizziness
□ Stroke
□ Bladder infection
□ Hepatitis
□ Asthma
□ Excessive thirst
□ Dermatitis/eczema/rash
□ Prostate problems
□ Miscarriage
□ Hysterectomy
□ Contraception use
□ Hormonal replacement
□ General fatigue
□ High blood pressure
□ Angina
□ Painful urination
□ Abnormal weight loss/gain
□ Drug/alcohol dependency
□ Epilepsy
□ General arthritis
□Muscular incoordination
□ Heart attack
□ Kidney stones
□ Loss of bladder control
□ Frequent urination
□ Loss of appetite
□ Tumor
□ Abdominal pain
□ Liver/gall bladder disorder
□ Smoking/tobacco use
□ Allergies
□ Cancer
□ Earache/infection
□ High cholesterol
□ None
□ Other: _____

Please describe the **treatment you received** for the above conditions and if any of the conditions are unresolved:

_____
_____
_____

Please list all the **surgical procedures** you have had, including the dates they were performed and other times you have been hospitalized:

_____
_____
_____

Family Health History:

Please indicate below which of the following conditions your family has a history of and/or an immediate family member has experienced:

□ Drug/alcohol dependency
□ Lung disease
□ Stroke
□ Bone/joint disorder
□ Autoimmune disease
□ Cancer
□ Depression
□ Diabetes
□ Blood disorder (e.g. anemia)
□ Heart disease
□ High blood pressure
□ High cholesterol
□ Migraine headaches
□ Osteoarthritis
□ Parkinson's disease
□ Huntington's disease
□ Thyroid problems
□ Kidney disease
□ Hepatitis
□ Liver disease
□ Psychiatric issues
□ Multiple sclerosis
□ Osteoporosis
□ Prostate issues
□ None
□ Other: _____
_____
_____

Medication/Vitamin Supplementation:

Please list all prescription and over-the-counter medications and nutritional/herbal supplements you are currently taking:

_____

_____

_____

Goals for Treatment:

Please indicate what your personal goals for treatment are:

□ Reduce pain/discomfort □ Increase range of motion □ Return to work/school □ Return to specific sport
□ Other:

_____

_____

_____