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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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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Pelvic Floor Questionnaire: Female

Name: _____ Date: _____

Thank you for taking the time to fill out this questionnaire. These questions will help your physical therapist understand the full scope of your health to better treat you. Please answer to the best of your ability. If you have any questions or concerns, leave the section blank and ask your therapist. If any section does not apply to you, simply leave it blank.

Pelvic Health History

Marital status: Married / Single / Widowed / Divorced / Significant Other

How many pregnancies have you had? Total: _____ Vaginal Deliveries: _____ Cesarean Sections: _____

Complications (check all that apply): □ Baby larger than 8 lbs. □ Forceps □ Severe tearing □ Episiotomy □ None

Did you have urinary leakage during or immediately after your pregnancy? □ Yes □ No

Menstrual history (check all that apply): □ Peri-menopause □ Post-menopause □ Pain with menses □ Irregular cycles

Are you currently pregnant? □ Yes □ No □ Possibly

What type of birth control do you use? _____

Chief Complaint

Please describe your symptoms:

_____

_____

When did your symptoms begin? _____

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

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

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

If you have pain/discomfort, please answer the following two questions (skip both if not):

1. What **type** of pain/discomfort do you have?
   □ pain □ numbness □ tingling □ stiffness
   □ soreness □ swelling □ weakness
2. 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%)

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----------|	

Which activities make your symptoms **worse** (i.e. sitting, sexual activity, etc.) ?

_____

_____

Which activities make your symptoms **better** (i.e. rest, pain medication, heat, etc.)?

_____

_____

Bladder Habits

How much do you drink each day of:

Clear liquids: _____

Caffeine (# of cups): _____

How many times do you urinate during the day? _____

How many times do you urinate during the night? _____

When do you leak urine (circle all that apply)?

Cough/sneeze	On the way to the restroom
Hear running water	Exercising
Jumping	Laughing
During sleep	During intercourse
Immediately after voiding	Other: _____

Do you have burning/pain with urination? □ Yes □ No

Do you have ***bladder*** pain? □ Yes □ No If yes, is it relieved after voiding? □ Yes □ No

Do you have difficulty starting a stream of urine? □ Yes □ No

Do you strain to empty your bladder? □ Yes □ No

Do you feel unable to fully empty the bladder? □ Yes □ No

Do you have a "falling out" feeling? □ Yes □ No

Do you have a strong urge to urinate? □ Yes □ No

Do you restrict your fluid intake due to fear of urinary leakage? □ Yes □ No

Do you use a form of leakage protection (check all that apply)

□ Pantiliner □ Maxi pad □ Incontinence pad □ Incontinence brief

How many pads do you use per day? _____

Bowel Habits

How many bowel movements do you have each day? _____

Most common stool consistency: □ Soft □ Liquid □ Formed □ Constipated

Do you strain to have a bowel movement? □ Yes □ No

Do you take laxatives/enema regularly? □ Yes □ No

Do you have pain with bowel movement? □ Yes □ No

Do you have a strong urge to move bowels? □ Yes □ No

Do you leak/stain bowel? □ Yes □ No

Do you have diarrhea often? □Yes □ No

Do you include fiber in your diet? □ Yes □ No

Sexual Activity

Gender of partner: □ Male □ Female

Are you sexually active? □Yes □ No

Do you have pain with penetration? □Yes □ No

Do you have pain with manual intercourse? □Yes □ No
Do you have pain with oral intercourse? □Yes □ No
Do you have pain with tampon use? □Yes □ No
Do you need lubrication? □Yes □ No
Are you able to achieve an orgasm? □Yes □ No
Do you have pain after sex? □Yes □ No
Do you feel safe in your current relationship? □Yes □ No
Have you ever been forced to engage in sexual activity against your will? □Yes □ No
Do you have a history of STD? □Yes □ No
What else would be helpful for us to know related to your care?

_____
_____

Treatment History

Have you received medical attention for your **primary complaint**? □ Yes □ No
If yes, what is the name of the **provider** who treated you? When did you **first seek medical attention** for your primary complaint? _____
What **diagnoses/treatment** was given for your primary complaint?

_____
How many times were you treated? Date of last treatment? _____
Did symptoms **get better/worse/remained the same** with past treatment? _____
Were **x-rays/CT scan/MRI/ultrasound images** taken? □ Yes □ No
If yes, what were the results? _____

Review of Systems

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

CONSTITUTIONAL SYMPTOMS:

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

EYES:

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

EARS/NOSE/THROAT:

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

RESPIRATORY:

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

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:

- □ Dairy
- □ Dander/dust
- □ Gluten
- □ Nuts
- □ Pollen
- □ Wheat
- □ Penicillin
- □ Bee sting
- □ Grass
- □ Shellfish
- □ None
- □ Other: _____

FEMALE:

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

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	□ General arthritis	□ Asthma	□ Liver/gall bladder disorder
□ Jaw pain	□ Chest pain	□ Excessive thirst	□ Kidney disorders
□ Neck pain	□ Abdominal pain	□ Dermatitis/eczema/rash	□ Kidney stones
□ Upper back pain	□ Heart attack	□ Allergies	□ Loss of bladder control
□ Mid back pain	□ Angina	□ Miscarriage	□ Frequent urination
□ Low back pain	□ High blood pressure	□ Hysterectomy	□ Bladder infection
□ Low back stiffness	□ High cholesterol	□ Contraception use	□ Prostate problems
□ Shoulder pain	□ Stroke	□ Hormonal replacement	□ Constipation
□ Arm/elbow pain	□ Ulcer	□ General fatigue	□ Painful urination
□ Wrist pain	□ Earache/infection	□ Diabetes	□ Smoking/tobacco use
□ Hand pain	□ Dizziness	□ Loss of appetite	□ Cancer
□ Hip/upper leg pain	□ Epilepsy	□ Depression	□ HIV/AIDS
□ Ankle/foot pain	□ Muscular incoordination	□ Abnormal weight loss/gain	□ Tumor
□ Leg numbness/tingling	□ Visual disturbances	□ Drug/alcohol dependency	□ None
□ Joint swelling/stiffness	□ Chronic sinusitis	□ Hepatitis	□ 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	□ Diabetes	□ Parkinson's disease	□ Multiple sclerosis
□ Lung disease	□ Blood disorder (e.g. anemia)	□ Huntington's disease	□ Osteoporosis
□ Stroke	□ Heart disease	□ Thyroid problems	□ Prostate issues
□ Bone/joint disorder	□ High blood pressure	□ Kidney disease	□ None
□ Autoimmune disease	□ High cholesterol	□ Hepatitis	□ Other: _____
□ Cancer	□ Migraine headaches	□ Liver disease	_____
□ Depression	□ Osteoarthritis	□ Psychiatric issues	_____

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:

_____

_____

_____