



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



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



**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



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.

Chief Complaint

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

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? _____

Do you leak urine? Yes No

If yes, 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 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

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

Do you have pain with erection? Yes No

Do you have pain with ejaculation? Yes No

Are you able to achieve an orgasm? Yes No

Do you have pain after sex? Yes No

Do you have pain with prolonged sitting? 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:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Malaise | <input type="checkbox"/> Loss of sleep (due to pain) | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of coordination/balance | <input type="checkbox"/> None |

EYES:

- | | | |
|---|---|---|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Double vision | <input type="checkbox"/> Poor vision at night |
| <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Nystagmus (involuntary eye movement) | <input type="checkbox"/> None |

EARS/NOSE/THROAT:

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Earache/infection |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Chronic sinusitis |
| <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> None |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Ringing in ears | |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Sinus problems | |

RESPIRATORY:

- | | | |
|---|--|-------------------------------|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> None |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing up blood | |

CARDIOVASCULAR:

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swollen ankles/feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> None |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Irregular heartbeat | |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Rapid heartbeat | |

GASTROINTESTINAL:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Gas | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Nausea | <input type="checkbox"/> None |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Ulcer | |

GENTOURINARY:

- 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? _____

Do you have a primary care physician? Yes No

What is your current height? _____

When was your **last** physical exam? _____

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

- | | | | |
|--|---|-------------------------------------|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Dancing | <input type="checkbox"/> Basketball | <input type="checkbox"/> Rock climbing |
| <input type="checkbox"/> Running | <input type="checkbox"/> Plyometrics | <input type="checkbox"/> Baseball | <input type="checkbox"/> TRX Suspension |
| <input type="checkbox"/> Aerobic classes | <input type="checkbox"/> Pilates | <input type="checkbox"/> Soccer | <input type="checkbox"/> Calisthenics |
| <input type="checkbox"/> Cross Fit | <input type="checkbox"/> Spinning classes | <input type="checkbox"/> Hockey | <input type="checkbox"/> Nautilus |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Yoga | <input type="checkbox"/> Football | <input type="checkbox"/> None |
| <input type="checkbox"/> Free weights | <input type="checkbox"/> Rowing | <input type="checkbox"/> Tennis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Martial arts | <input type="checkbox"/> Swimming | <input type="checkbox"/> 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**.

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Drug/alcohol dependency | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson’s disease | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Blood disorder (e.g. anemia) | <input type="checkbox"/> Huntington’s disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Prostate issues |
| <input type="checkbox"/> Bone/joint disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Liver disease | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> 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:
