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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WC Intake Form

Name: _____ Date: _____

Mechanism of Injury

Date of the work-related injury: _____ Time of injury: _____

Where did injury occur? _____

Please describe the **how the injury occurred** in your own words:

_____

_____

_____

_____

_____

Please describe the **environmental conditions** which may have contributed to your present injury (e.g. poor lighting, slippery floor, limited space, etc.). Be sure to distinguish natural hazards from hazards created by other employees.

_____

_____

_____

_____

What was your **immediate response** after the work-related injury?

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

When was your **last date** of work? _____

What is your **current** work status?

□ Full-time □ Part-time □ Overtime □ Light/restricted duty

Were there any witnesses to the injury? □ Yes □ No What date did you report this injury? _____

Whom did you report this injury to? _____

Medical Attention

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

If yes, please describe: _____

_____

Have you received medical attention **since the initial injury**? □ Yes □ No If yes, what date? _____

If yes, what doctor/hospital/clinic did you go to? _____

If yes, what **treatment/diagnosis** was given? _____

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

What percentage have your symptoms **improved from past treatment**? _____

How many times have you been seen **since the injury**? _____ Date of last treatment? _____

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

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

Please provide a detailed job description including what you do on a regular basis, how much weight you lift on average, how much walking/standing/sitting you do, and describe any repetitive movements, etc:

_____

_____

_____

_____

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

- -

Do you have a **SECOND** job? □ Yes □ No

If yes, what is your **second** 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

Please provide a detailed job description including what you do on a regular basis, how much weight you lift on average, how much walking/standing/sitting you do, and describe any repetitive movements, etc:

_____

_____

_____

_____

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

Current Symptoms:

Check **ALL** the symptoms that have become apparent **SINCE THIS INJURY** (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?

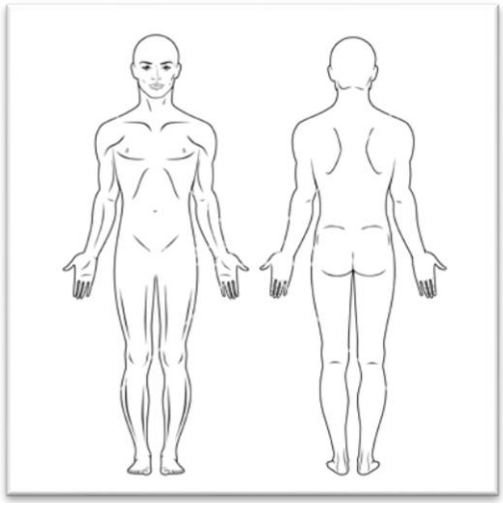
□ pain □ numbness □ tingling □ stiffness
□ soreness □ swelling □ weakness

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 work-related injury, were you experiencing symptoms of any kind? □ Yes □ No

If yes, please describe:

_____

_____

What **percentage of improvement** did you experience with previous treatment? _____

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

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? _____ Where the results normal/abnormal? _____

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? _____

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? _____

Personal Health History:

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

□ Headaches
□ Jaw pain
□ Neck pain
□ General arthritis
□ Chest pain
□ Abdominal pain
□ Asthma
□ Excessive thirst
□ Dermatitis/eczema/rash
□ Liver/gall bladder disorder
□ Kidney disorders
□ Kidney stones

□ Upper back pain
□ Mid back pain
□ Low back pain
□ Low back stiffness
□ Shoulder pain
□ Arm/elbow pain
□ Wrist pain
□ Hand pain
□ Hip/upper leg pain
□ Ankle/foot pain
□ Leg numbness/tingling
□ Joint swelling/stiffness
□ Heart attack
□ Angina
□ High blood pressure
□ High cholesterol
□ Stroke
□ Ulcer
□ Earache/infection
□ Dizziness
□ Epilepsy
□ Muscular incoordination
□ Visual disturbances
□ Chronic sinusitis
□ Allergies
□ Miscarriage
□ Hysterectomy
□ Contraception use
□ Hormonal replacement
□ General fatigue
□ Diabetes
□ Loss of appetite
□ Depression
□ Abnormal weight loss/gain
□ Drug/alcohol dependency
□ Hepatitis
□ Loss of bladder control
□ Frequent urination
□ Bladder infection
□ Prostate problems
□ Constipation
□ Painful urination
□ Smoking/tobacco use
□ Cancer
□ HIV/AIDS
□ Tumor
□ None

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