

NEW HEIGHTS PHYSICAL THERAPY

1700 Broadway St., Suite 101, Vancouver, WA 98663
Ph (360) 737-3346, Fax (360) 694-7356

Welcome to New Heights Integrative Therapy, Inc. and thank you for selecting our clinic for your health care needs. We value your time and realize that office visits may be an interruption in an otherwise very busy schedule for you. For this reason, we've taken steps to assure that your time in the clinic is as focused and efficient as it can be. Please note the following:

- **Paperwork:**

In order for us to learn about your personal health goals and to be better prepared for your examination, we are enclosing new patient forms. Your detailed and thoughtful responses will help us to use our time in the clinic more effectively. Please complete the forms and bring them with you at the time of your appointment along with your doctor referral, if you have one.

- **Cancellation Policy:**

Please provide us with notice of cancellation at least **24 hours in advance** of your scheduled appointment. This requirement is waived if you are ill. If you fail to show up for a scheduled appointment, there will be a \$25.00 cancellation fee.

- **What to wear:**

Because we are an environmentally sensitive clinic, we ask that you refrain from wearing any scented products on the day of your appointment. We do not have any dress requirements, but you may want to bring a pair of comfortable shorts to your first visit; a gown will be provided for you, if necessary.

- **Billing:**

If you have health insurance, New Heights will gladly assist with insurance billing. Please provide us with your insurance information at the beginning of your scheduled visit. In the event New Heights are out-of-network providers with your insurance company, you have the option of: paying at the time of service and receiving a discounted rate or having us bill your insurance company for you. However, if your insurance company does not pay in full, you are responsible for the balance on your account. We accept cash, personal checks, Visa, MasterCard, HSA and Care Credit.

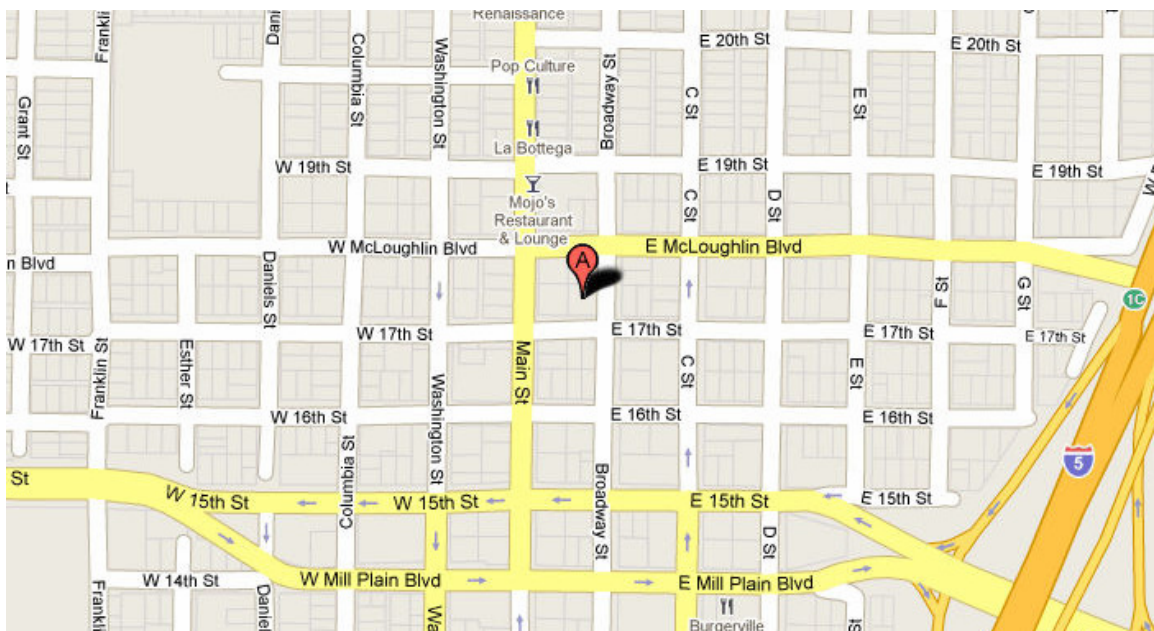
- **Location:**

Our clinic is located on the SW corner of Broadway St and 17th St. Please refer to the map provided. Parking is available on the surrounding neighborhood streets and metered parking on the 17th St.

We look forward to seeing you in our clinic. Our goal is always to provide you with health care that exceeds your expectations.

Sincerely,

New Heights Integrative Therapy, Inc.





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CONDITIONS OF REGISTRATION

Patient Name: _____

Thank you for trusting New Heights Integrative Therapy with your physical therapy needs. We take our commitment to you very seriously and look forward to working with you to enhance your health and well-being.

By signing the authorization for consent to treatment and New Heights Integrative Therapy registration form, patient acknowledges and agrees to the following:

1. RELEASE OF INFORMATION: I authorize New Heights Integrative Therapy to release my medical records to my health insurance for the purpose of billing and processing of my claim. I also agree to allow New Heights to release my medical records and discuss health related and financially related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. A photocopy or a faxed copy of the release may be used in place of the original.

2. ASSIGNMENT OF INSURANCE BENEFITS: New Heights has my permission to submit billings to my insurance company on my behalf and I authorize these payments to be made directly to New Heights Integrative Therapy. I agree to pay all outstanding balances on my account within 30 days of receiving a balance due statement. I also agree to pay all insurance co-payments, deductibles and non-covered charges at the time of service. Should my account be referred to an attorney or collection agency for collection, I will pay actual attorney fees and collection expenses.

3. CANCELLATION AND MISSED APPOINTMENT POLICY: In the event that I am unable to make a scheduled appointment I understand that I must give at least **24 hours notice (1 business day)** prior to my scheduled appointment. **Failure to do so will result in a missed appointment fee in the amount of \$25 for scheduled therapy appointments. Payment will be made prior to my next appointment.** I understand that my insurance company will not pay for missed appointments. Furthermore, failure to attend three scheduled sessions without notification may result in termination of all future appointments. This policy enables New Heights to schedule other clients who are in need of service in a prompt and timely manner.

4. RETURNED CHECK POLICY: In the event that my payment is returned for non-sufficient funds I will be charged a \$25 processing fee.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to New Heights Integrative Therapy, Inc., and I understand that I am financially responsible for any balance per the credit policies of New Heights Integrative Therapy, Inc. I certify that I have read, understand, and agree to all of the conditions of registration, and request and consent to the above named patient to receive appropriate services from New Heights Integrative Therapy, Inc.

Patient / Guarantor Signature: _____ **Date:** _____

Print Patient / Guarantor Name: _____ **Relationship:** _____

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Initial Evaluation Subjective Report

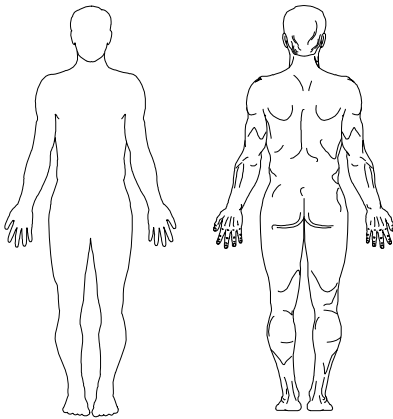
Name: _____ DOB: _____ Age: _____ Date of Service: _____

1. What are your symptoms? Please specifically describe your symptoms _____

Please indicate location of your symptoms:

Front

Back



2. When did your symptoms begin? _____

3. Was the onset of your symptoms gradual or sudden (Circle one)?

4. How did your injury occur? _____

5. Since onset, are your symptoms getting:

Better Worse Staying the Same

6. Have you had similar symptoms in the past? Yes No

7. What is the nature of your pain/symptoms?

Sharp Aching Dull Throbbing

Periodic Constant Occasional Other _____

8. As the day progresses do your symptoms:

Increase Decrease Stay the same

9. Does the pain wake you at night? No Yes

If yes: When lying still, changing positions or both? (Circle one)

10. Do you have pain/stiffness upon getting out of bed in the

morning? Yes No

11. In what position do you fall asleep?

On your stomach On your back On your side

12. Do you have trouble falling asleep? Yes No

13. Is your sleep restful? Yes No

14. On what type of surface do you sleep?

Firm Soft Sagging / Waterbed Other: _____

15. How many times do you awaken during the night? _____ How long before you go back to sleep? _____

16. What positions, activities, and time of day **aggravate** your symptoms? _____

What positions, activities, and time of day **relieve** your symptoms? _____

What specific activities are you **unable to do** because of your symptoms? _____

17. Have you had any previous treatment for this condition?

Medication

Manipulation by DC or DO

Exercise

Physical Therapy

Traction

Naturopathic Doctor (ND)

Acupuncture

Massage Therapy

Oriental Medicine Doctor

Injection

Bracing/taping

Other _____

18. Have you had any tests done relating to your condition?

X-ray

MRI

CT Scan

Bone Scan

Arthrogram

Lab Tests Other _____

Results: _____

19. Are you currently taking any medications or supplements, either prescription or over the counter? Please list. _____

20. Do you have any allergies to food or medication? If yes, please list _____

21. Place three circles on the scale below to indicate the intensity of your pain at its best, on the average and at its worst.

0 1 2 3 4 5 6 7 8 9 10
No Pain..........Worst Pain Imaginable

Patient Goals: _____

PREVIOUS FUNCTIONAL LEVEL

- Independent in all activities (work, community, home, recreation)

SELF CARE

- Independent in all self-care (bathing, toileting, dressing, etc.)
- Difficulty performing self-care activities
- Need assistance with self-care activities
- Difficulty performing household chores

SOCIAL

- Need assistance with activities in community outside of home

Hobbies: _____

WORK HISTORY

Occupation: _____

- Employed full time Student
- Employed part time Retired
- Self employed Unemployed
- Home maker Other: _____

Physical activities at work:

- Sitting Computer use
- Standing Heavy equipment
- Phone use Driving
- Repetitive or heavy lifting Other: _____

LIVING SITUATION

- Live alone In a home/apartment
- Live with family member/others In a retirement complex (SNF/ICF)
- Live with caregiver In an assisted living complex
- Other: _____

Home Setting (Check all that apply):

- Stairs w/ railing Ramp
- Stairs w/ no railing Elevator
- No stairs Uneven ground
- Other: _____

GENERAL HEALTH

How would you rate your general health?

- Excellent Good Average Fair Poor

Nutritional Habits:

How many caffeinated beverages do you drink per day? _____

Do you have a prior or current history of smoking? Yes No

How many packs of cigarettes do you smoke a day now? _____

Current Eating Habits:

Do you eat 3 meals a day? Yes No

Do you consider them to be balanced meals? Yes No

Do you have a history of headaches after eating certain foods? Yes No

Did you do exercise outside of normal daily activities?

- 5+ days/week Occasionally
- 3-4 days/week Zero
- 1-2 days/week

Exercise, Sports/Recreation consisting of _____

Name: _____

DOB: _____

MEDICAL HISTORY

Name: _____

DOB: _____

On the scale below please indicate your activity level due to your present condition as compared to your previous activity level before injury.

<i>Inactive.....</i>											<i>.....Normal</i>
On a good day:	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
On a bad day:	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Please Circle Any Applicable Conditions:

Infection:

Hx of: TB, bone, heart valve, kidney, chronic lung, abscesses, skin, hepatitis B,C, HIV/ Aids, Lymes.
Circle if recent: temp, chills, night sweats, rash

Lung:

Hx of: Asthma (normal peak flow _____), bronchitis, TB, Pneumothorax, Pulmonary Embolus, Pulmonary Hypertension. Circle if recent: cough, sputum, shortness of breath, hoarseness, pain worse with deep breath, other _____

Heart:

Hx of: Heart attack, angina, valve disorder, arrhythmia-fast, slow, heart block, cardiac arrest, implantable defibrillator, pacemaker, congestive heart failure, cardiac hypertrophy, myocarditis, heart transplant, bypass surgery, high blood pressure. Circle if recent symptoms of: chest, arm, jaw pain with exercise, palpitations, fainting, other _____

Blood Vessels:

Deep vein thrombosis, arteriosclerosis of leg vessels, artery bypass surgery. Circle if recent symptoms: calf pain with walking, enlargement of calf or thigh, cold legs, leg or calf pain at rest.

Gastrointestinal:

Ulcer, appendix surgery, gall bladder stones, infection, colitis, crohns, sprue. Circle if recent symptoms: nausea, vomiting, belly pain, diarrhea, bloody stool, change in stools, swallowing difficulties, other _____

General:

Chronic Fatigue Syndrome. Circle if recent symptoms: fatigue, weakness, insomnia, weight loss or gain, other _____

Kidney:

Kidney infection, kidney stone(s). Circle if recent symptoms: pain with urination, facial swelling, no urination for 24 hours, loss of urine control

Reproductive Organs:

Men: Prostate infection, hernia, urethra infection

Females: Birth control pills, ovarian cysts, endometriosis, last period or menopause date _____, ectopic pregnancy, presently pregnant. Circle if recent symptoms: excessive vaginal bleeding, pelvic pain.

Hormonal: Thyroid condition, osteoporosis, osteomalacia, diabetes (year of onset _____), diabetes complications _____

Rheumatologic:

Rheumatoid Arthritis, Fibromyalgia, Lupus, Sjogrens, Scleroderma, Psoriatic arthritis, Ankylosing Spondylitis, Reiters Syndrome. Circle if recent symptoms: joint swelling or deformity, muscle aching, other _____

Neurologic:

Seizure, multiple sclerosis, guillain-barre syndrome, ALS, Disc Bulge. Circle if recent symptoms: Left or Right leg weakness, pain, tingling, loss of sensation, right or left arm weakness, pain, tingling, loss of sensation.

Skin:

Cellulitis, Psoriasis, Hives, painful cyst, rash, red streaks, other _____

Spine / Orthopedic / Bone:

Fractures, dislocation, sprains, neck / back problem, motor vehicle injury, and other traumas.

Drug Abuse:

Pain medication, cocaine, other _____, anxiety drugs, alcohol use.

Psychiatric:

Severe depression, panic attack, psychotic disorder, borderline disorder, suicide attempt, other _____

Blood / Cancer:

Anemia, bleeding disorder. List any cancer and dates: _____

Type of Surgery & Date:

Describe and detail any of the preceding conditions:

Name: _____

DOB: _____