



1700 Broadway Street, Vancouver, Washington 98663
Ph (360) 737-3346, Fax (360) 694-7356

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 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.

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 Guarantor Name: _____ Relationship: _____

NEW HEIGHTS

INTEGRATIVE THERAPY INC.

1700 Broadway Street, Vancouver, Washington 98663
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Initial Evaluation Subjective Report

Date: _____

Name: _____ Age: _____ DOB: _____

Occupation: _____ Work Status: Normal Schedule, Light Duty, Reduced Hours, Off Work

Height: _____ Weight: _____ Handedness: Right Left

Referring Physician: _____ Diagnosis: _____

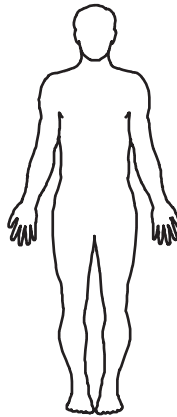
Date of Injury: _____ Date of Surgery: _____

1. What major complaint, symptom or problem brings you here?

2. Describe your symptoms specifically:

Please indicate the location of your symptoms:

- xxxx Moderate Pain
- Severe Pain
- Shooting Pain
- ///// Numbness



Front



Back

3. How did your symptoms begin, and how have they progressed?

4. Are your symptoms getting:

- Better Worse Staying the Same

5. Are your symptoms Constant or intermittent (circle one)?

If intermittent: How often do they occur?

How long do they last? _____

6. 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

7. Do you have trouble falling asleep? Yes No
 Is your sleep restful? Yes No
 In what position do you fall asleep?
 On your stomach On your back On your side
 On what type of surface do you sleep?
 Firm Soft Sagging / Waterbed Other: _____
 How many times do you awaken during the night? _____
 How long before you go back to sleep?
8. What positions, activities, and time of day increase you pain?

9. What positions, activities, and time of day decrease your pain?

10. What specific activities are you unable to do because of your symptoms?

11. On the scale below please indicate your activity level due to your present condition as compared to your previous activity level before injury.
- Inactive.....* *.....Normal*
- 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%
12. Have you seen any of the following during the past three months?
- | | | |
|--|--|---|
| <input type="checkbox"/> Medical Doctor (MD) | <input type="checkbox"/> Osteopath (DO) | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Chiropractor (DC) | <input type="checkbox"/> Naturopathic Doctor (ND) |
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Oriental Medicine Doctor |
| <input type="checkbox"/> Other _____ | | |
13. Have you had any of the following tests performed for this problem?
- | | | | | |
|---|------------------------------|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> X-ray | <input type="checkbox"/> MRI | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Arthrogram |
| <input type="checkbox"/> Lab Tests <input type="checkbox"/> Other _____ | | | | |
- Results: _____
14. List all prescription and non-prescription medications:
 List: _____
15. Allergies: Medications Other
 List: _____
16. Exercise Pattern when injury free (activities, frequency, and future goals):

MEDICAL HISTORY

Please Circle If Recent Or Ongoing:

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:

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 food allergies? Yes No

List: _____

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

List Specific Foods: _____

Patient Goals: _____

(Patient)

(Date)