New Heights
PHYSICAL THERAPY +

Welcome to New Heights Physical Therapy 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 call us with notice of cancellation at least **24 hours in advance** of your scheduled appointment. A $50 fee will be assessed for a missed appointment or cancellation unless 24 hour notice is given. Please refer to the full Cancellation and Missed Appointment Policy for more detailed information.
  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:**
  We offer three locations for your physical therapy needs: East Portland, West Portland and Vancouver. Please refer to the map provided

East Portland

5736 NE Glisan St. – Located on the south side of NE Glisan between NE 57th and NE 58th.

West Portland

13306 NW Cornell Road – Located on the south side of Cornell Road, just off Murray Blvd.

Vancouver

1700 Broadway ST., Suite 101 – Located on the west side of Broadway St. between 17th and 18th.

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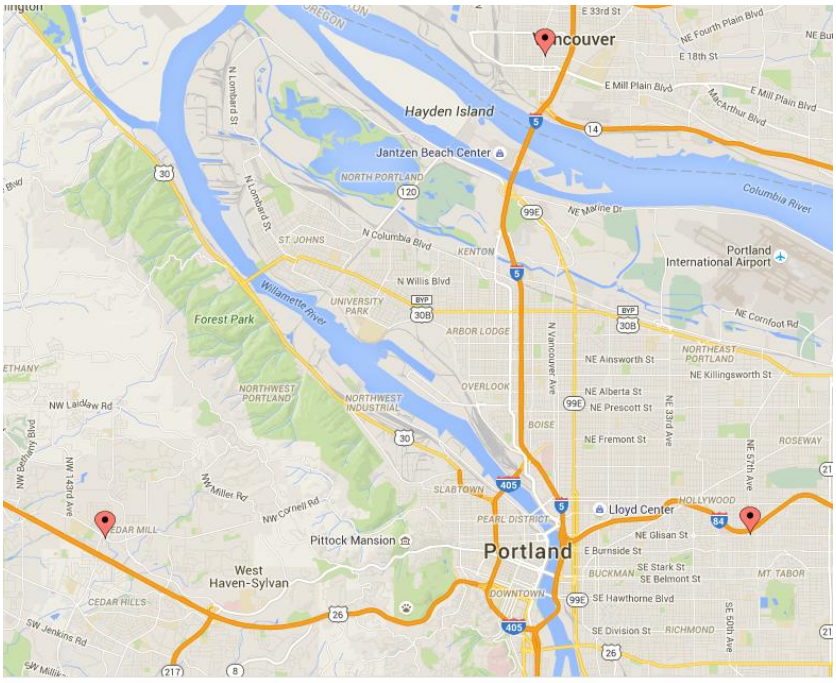

We look forward to seeing you in our clinic. Our goal is always to provide you with health care that exceeds your expectations.

Sincerely,
New Heights Physical Therapy

CONDITIONS OF REGISTRATION

Patient Name: _____ DOB: _____
Please Print

1. Release of Information: I authorize New Heights Physical Therapy Plus* 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. Initial here_____

2. Assignment of Insurance Benefits / Financial responsibility: 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, Inc. 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. **I acknowledge that verification of insurance benefits is provided as a courtesy and NOT a guarantee of payment.**

Initial here_____

3. **Notice of Privacy Practices:** I acknowledge that I have been offered a copy of the NHPT notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by NHPT and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Initial here_____

4. Cancellation and Missed Appointments: A fee will be assessed for a missed appointment or a cancellation unless a 24 hour notice is given. Additionally, tardiness in excess of 20 minutes may result in rescheduling your appointment. The full Cancellation and Missed Appointment Policy will be posted within the clinic for your review.

Initial here_____

5. Emergency Contact: Name:_____ Phone:_____ Relationship:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to New Heights Physical Therapy Plus, and I understand that I am financially responsible for any balance owed to New Heights Physical Therapy Plus. 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 Physical Therapy Plus.

Patient / Guarantor Signature: _____Date: _____

Print Patient / Guarantor Name: _____ Relationship: _____

*DBA of New Heights Integrative Therapy, Inc.

New Heights
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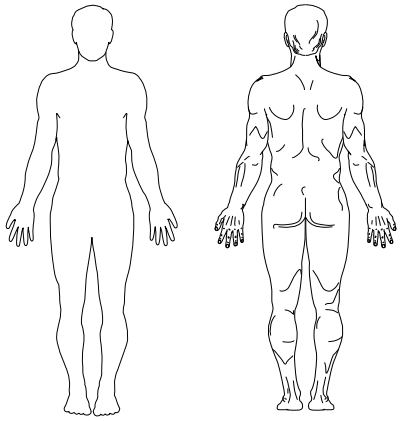
Initial Evaluation Subjective Report

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

1. When did your symptoms begin? initial injury_____ most recent exacerbation_____
2. Surgery performed? □ Yes □ No If Yes, type of surgery_____ date of surgery_____
3. How did your injury occur? _____
4. What are your symptoms? Please specifically describe_____
_____
_____

5. Please indicate location of your symptoms:

Front Back



6. Since onset, are your symptoms getting:
□ Better □ Worse □ Staying the Same
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 □ Both
10. Do you have pain/stiffness upon getting out of bed in the morning?
. □ Yes □ No
11. Please indicate your PREVIOUS functional level (prior to injury):
□ Independent in all activities (work, community, home, recreation)
□ Independent in all self-care (bathing, toileting, dressing, etc.)
□ Difficulty performing self-care activities
□ Need assistance with self-care activities
□ Difficulty performing household chores
□ Need assistance with activities in community outside of home

12. CURRENT functional level: What specific activities are you ***unable to do*** because of your symptoms?
_____
13. Place three circles on the scale below to indicate the intensity of your pain at its **best**, **current,** and **worst**.

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

14. What positions, activities, and time of day ***aggravate*** your symptoms?_____
_____
15. What positions, activities, and time of day ***relieve*** your symptoms? _____
_____
16. Have you had similar symptoms in the past? □ Yes □ No If Yes, please explain_____
_____

New Heights
PHYSICAL THERAPY

SOCIAL HISTORY

Occupation: title: _____

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

Physical activities at work:

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

Living Situation:

- ☐ Live alone
- ☐ Live with others
- ☐ Live with caregiver
- ☐ Other: _____
- ☐ Home/apartment
- ☐ Retirement complex
- ☐ Assisted living complex

Home Setting:

- ☐ Stairs with railing
- ☐ No stairs
- ☐ Elevator
- ☐ Other: _____
- ☐ Stairs, no railing
- ☐ Ramp
- ☐ Uneven ground

TREATMENT HISTORY

Have you had any previous treatment for this condition?

- ☐ Medication
- ☐ Physical Therapy
- ☐ Acupuncture
- ☐ Injection
- ☐ Manipulation by DC or DO
- ☐ Traction
- ☐ Massage Therapy
- ☐ Bracing/taping
- ☐ Exercise
- ☐ Naturopathic Doctor (ND)
- ☐ Oriental Medicine Doctor
- ☐ Other _____

Have you had any tests done relating to your condition?

- ☐ X-ray
- ☐ MRI
- ☐ CT Scan
- ☐ Bone Scan
- ☐ Arthrogram
- ☐ Lab Tests
- ☐ Other _____
- ☐ Results:_____

MEDICATIONS

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

_____

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

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

Sleep Habits:

In what position do you fall asleep? ☐stomach ☐back ☐ side (Right/Left) – please circle one

Do you have trouble falling asleep ☐ Yes ☐ No

Is your sleep restful? ☐ Yes ☐ No

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? _____

Exercise Habits:

Did you do exercise outside of normal daily activities?

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

Exercise, Sports/Recreation consisting of _____

Patient Goals: _____

_____

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.

	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%

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 _____), bronchititis, 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 (ALL surgeries related and unrelated):
_____
_____

Describe and detail any of the preceding conditions:
_____
_____
_____

Name: _____ DOB: _____

* New Heights Physical Therapy Plus is a DBA of New Heights Integrative Therapy Inc.