CONDITIONS OF REGISTRATION

Patient Name: _____ DOB: _____

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.

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.**

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.

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.

5. Emergency Contact: _____ 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: _____

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Name: _____ Date: _____ Date of Birth: _____ Age: _____

Nickname: _____

Preferred Pronoun: _____ Gender: _____

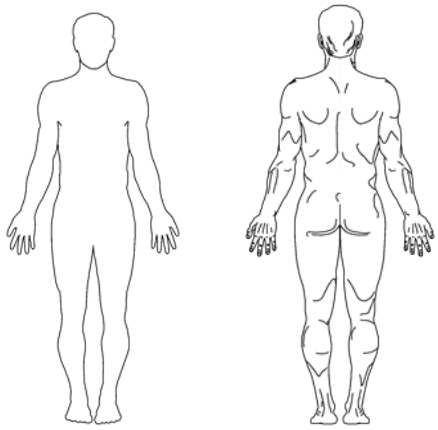
To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your Physical Therapist can assist you. Thank you for your time.

1) Reason for Visit?

_____

_____

Shade in region(s) of pain or abnormal sensation:



2) When did your symptoms begin?

_____

3) Surgery Performed? ❑ Yes ❑ No

Type:_____

Date of Surgery:_____

4) Was the onset/time of this episode:

❑ Gradual ❑ Sudden

Any previous episodes? ❑ Yes ❑ No

5) How did your injury occur?

- ❑ Unknown
- ❑ Car Accident
- ❑ Trauma
- ❑ Overuse
- ❑ Degenerative Process
- ❑ During recreation/sports
- ❑ Other_____
- ❑ While lifting
- ❑ A fall
- ❑ At work
- ❑ Dental

6) Since the onset, are your symptoms getting:

❑ Better ❑ Worse ❑ Staying the Same

7) Nature of pain/symptoms:

- ❑ Sharp ❑ Aching ❑ Dull
- ❑ Throbbing ❑ Periodic ❑ Constant
- ❑ Occasional
- ❑ Other: _____

8) Rate your pain on scale of 0-10 below. Place 3 circles: (**Best, Current, Worst**)

0 1 2 3 4 5 6 7 8 9 10

No Pain…… **……Worst Pain Imaginable**

9) As the day progresses, do your symptoms:

❑ Increase ❑ Decrease ❑ Stay the Same

10) Does your pain wake you at night:

- ❑ Yes ❑ No
- ❑ While lying down
- ❑ Only with changing positions

11) What Position do you sleep?

- ❑ Back ❑ Stomach ❑ Chair/recliner
- ❑ Right side ❑ Left side

12) Average amount of sleep per night? _____

13) Do you wake with stiffness in the morning?

❑ Yes ❑ No

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PHYSICAL THERAPY +

Name: _____ Date: _____ Date of Birth: _____ Age: _____

14) **Previous** Functional Level:

- ❑ Independent in all activities
- ❑ Independent in all self-care
- ❑ Difficulty performing self-care activities
- ❑ Need assistance with self-care activities
- ❑ Difficulty performing household chores
- ❑ Need assistance with activities in community outside of home

15) **Current** Functional Level: What specific activities are you unable to do because of your symptoms?

_____

_____

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

_____

_____

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

_____

_____

18) Have you had similar symptoms in the past?

_____

_____

19) Occupation:_____

❑ Full-time ❑ Part-time ❑ Self-Employed
❑ Student ❑ Retired ❑ Unemployed

20) Have you had previous treatment for this condition?

❑ Medication ❑ Injection
❑ Manipulation DC/DO ❑ Exercise
❑ Physical Therapy ❑ Traction
❑ Naturopathic Doctor ❑ Acupuncture
❑ Injection ❑ Bracing/Taping
❑ Massage Therapy ❑ Oriental Medicine
❑ Other _____

21) Have you had any tests done relating to your condition?

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

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

_____

_____

23) Do you have any allergies to food or medications?

_____

_____

24) How would you rate your general health?

❑ Excellent ❑ Good ❑ Average
❑ Fair ❑ Poor

25) Do you have a prior or current history of smoking?

❑ No ❑ Yes;
How many packs a day? _____

26) How frequently do you exercise outside of normal daily activities?

❑ 5+ days/wk ❑ 3-4 days/wk ❑ 1-2 days/wk
❑ Occasionally ❑ Zero
What type of exercise/sports?
_____

27) What are your goals coming to Physical Therapy?

_____

_____

28) Please indicate your activity level due to your present condition as compared to your previous level before injury.

Inactive..... .....**Normal**
On A Good Day:
0%------20%------40%------60%------80%-----100%
On A Bad Day:
0%------20%------40%------60%------80%-----100%

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Name: _____ Date:_____ Date of Birth:_____ Age:_____

MEDICAL HISTORY

As you review the following list, please check any problems or conditions that you are currently experiencing or have experienced.

General Health
- ❑ Good General Health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Chronic Fatigue Syndrome
- ❑ Fever/Chills
- ❑ Other:_____

Spine/Orthopedic/Bone
- ❑ Back Pain
- ❑ Neck Pain
- ❑ Joint Pain
- ❑ Muscle Pain/Stiffness
- ❑ Difficulty Walking
- ❑ Fractures
- ❑ Dislocations
- ❑ Swelling
- ❑ Other:_____

Ears, Eyes, Nose, Mouth, Throat
- ❑ Change in Taste/Smell
- ❑ Change in swallow/chewing
- ❑ Ringing in Ears
- ❑ Sinus Infection
- ❑ Recent dental work
- ❑ Change in Vision
- ❑ Other:_____

Gastrointestinal
- ❑ Constipation/Diarrhea
- ❑ Nausea/Vomiting
- ❑ Painful Bowel Movements
- ❑ SIBO
- ❑ Stomach/Abdominal Pain
- ❑ Ulcer
- ❑ Crohns
- ❑ Bowel Incontinence
- ❑ Other:_____

Rheumatologic
- ❑ Rheumatoid Arthritis
- ❑ Fibromyalgia
- ❑ Auto-Immune Disorders
- ❑ Psoriatic Arthritis
- ❑ Ankylosing Spondylitis
- ❑ Other:_____

Urinary
- ❑ Kidney Stones/Infection
- ❑ Frequent UTI/Bladder Infections
- ❑ Urinary Incontinence/Urgency
- ❑ Urinary Retention
- ❑ Painful Urination
- ❑ Other:_____

Reproduction
- ❑ Testicle Pain
- ❑ Prostate Disease
- ❑ Sexual Difficulty
- ❑ Irregular Periods
- ❑ # Pregnancies:_____
- ❑ Currently Pregnant
  # of weeks:_____
- ❑ Currently Breastfeeding
- ❑ STD
- ❑ Endometriosis
- ❑ Oral Birth Control Pills
- ❑ Ovarian Cysts
- ❑ PCOS
- ❑ Pelvic Pain
- ❑ Other:_____

Blood
- ❑ Deep Vein Thrombosis
- ❑ Arteriosclerosis
- ❑ Artery Bypass Surgery
- ❑ Calf pain
- ❑ HIV/AIDS
- ❑ Cancers
- ❑ Other:_____

Cardiac
- ❑ History of Heart Attack
- ❑ Angina
- ❑ Implantable Defibrillator
- ❑ Pacemaker
- ❑ Congestive Heart Failure
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Bypass surgery
- ❑ Other:_____

Neurologic
- ❑ Seizure
- ❑ Concussion
- ❑ Traumatic Brain Injury
- ❑ Stroke
- ❑ Disc Bulge/Herniation
- ❑ Dizziness/Vertigo
- ❑ Memory Loss
- ❑ Migraine Headaches
- ❑ Balance Difficulties
- ❑ Other:_____

Skin
- ❑ Cellulitis
- ❑ Psoriasis
- ❑ Hives
- ❑ Rash/Itching
- ❑ Other:_____

Psychiatric
- ❑ Severe Depression
- ❑ Panic Attack
- ❑ Psychotic Disorder
- ❑ Borderline Disorder
- ❑ Suicide Attempt
- ❑ Other:_____

Cancer
- ❑ History of Cancer
  Type:_____
  Treatment:_____
- ❑ Blood Disorder
- ❑ Other:_____

Surgical History
- ❑ Types of Surgery and Surgical
  Dates:_____
  _____
  _____
  _____
  _____