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: 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:** _________________

New Heights
PHYSICAL THERAPY

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:______________________
  ____
  ____
  ____
  ____

New Heights
PHYSICAL THERAPY

Name: ______________________________ Date:_________________ Date of Birth:______________ Age:______

Nickname:____

Preferred Pronoun:_____________ Gender:_________________

Pelvic Floor Intake Questionnaire

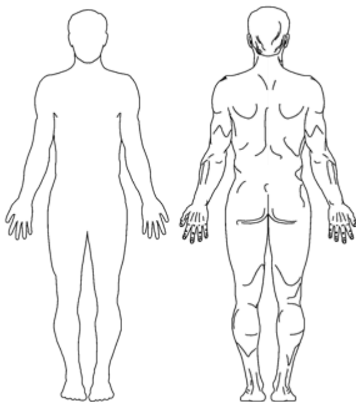
To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your Physical Therapist can assist you. Thank you for your time.

1) Reason for Visit?

____

____

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



2) When did your symptoms begin?

____

3) Was the onset/time of this episode:

❑ Gradual ❑ Sudden

Any previous episodes? ❑ Yes ❑ No

4) How did your injury occur?

❑ Childbirth
❑ Car Accident
❑ Trauma
❑ Overuse
❑ Degenerative Process
❑ During recreation/sports
❑ Other___________________________________
❑ While lifting
❑ A fall
❑ At work
❑ Unknown

5) Since the onset, are your symptoms getting:

❑ Better ❑ Worse ❑ Staying the Same

6) Nature of pain/symptoms:

❑ Sharp ❑ Aching ❑ Dull
❑ Throbbing ❑ Periodic ❑ Constant
❑ Occasional ❑ Cramping ❑ Fullness
❑ Itching ❑ Shooting ❑ Burning
❑ Other: ________________________________

7) 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**

8) As the day progresses, do your symptoms:

❑ Increase ❑ Decrease ❑ Stay the Same

9) **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

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

____

____

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

____

____

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

____

____

New Heights
PHYSICAL THERAPY +

Name: ______________________________ Date:_________________ Date of Birth:______________ Age:______

OB/GYN Pelvic History

of Pregnancies__________________ # of Vaginal Deliveries__________ # C-Section Deliveries ___________________________

Birth weight of largest baby_________ # of Episiotomies______________ Date of last pap smear___________________________

Did you have trouble healing after delivery? ❑ No ❑ Yes ____

Any complications with child birth? ❑ No ❑Yes ____

Are you having regular menstrual cycles? ❑ No ❑ Yes Are you currently breast feeding? ❑ No ❑ Yes

Menopause – when? ❑ No ❑ Yes __________

Difficulties with (check all that apply):

❑ Prolapse or organ falling out ❑ Vaginal dryness ❑ Painful Periods ❑ Painful vaginal penetration

❑ Pelvic Pain ❑ Other: ____

Pelvic History

History of (check all that apply):

❑ Sexual abuse/trauma ❑ Abdominal Separation ❑ Frequent Urinary Tract Infections

❑ Sexually Transmitted Diseases, Past and Current:____

❑ Pelvic/Abdominal Surgeries ____

Difficulties with (check all that apply):

❑ History of Prostate Disorders ❑ History of Erectile Dysfunction ❑ Painful Ejaculation ❑ Pelvic Pain

❑ Other:____

Bladder Symptoms

Do you lose urine when you (check all that apply):

❑ Cough/Sneeze/Laugh ❑ Lift/Exercise/Jump ❑ Hear Running Water ❑ Walking to the Bathroom

❑ Have a strong urge to urinate ❑ With Intercourse ❑ Other:______________________________________

Difficulties with (check all that apply):

❑ Wetting the bed ❑ Burning/Pain with Urination ❑ Difficulty Starting Urine Stream

❑ Strain to empty bladder ❑ Have a falling out feeling ❑ Feel unable to empty bladder fully

❑ Pain with a full bladder ❑ Have strong urge to urinate ❑ Urinate more than 7 times per day

❑ Dribbling after urination ❑ Blood in urine

Frequency of Urination: During the day: _____________ ; Sleep Hours: ____________

Bowel Symptoms

Difficulties with (check all that apply):

❑ Strain to have a bowel movement ❑ Leak/Stain Feces ❑ Use of laxatives/enemas regularly

❑ Constipation ❑ Pain with Bowel Movement ❑ Leak gas by accident

❑ Strong urge to move your bowels ❑ Diarrhea ❑ Must include extra fiber in diet

Frequency of Bowel Movements: Per Day or Week: ____________________________

Most Common Stool Consistency: ❑ Liquid ❑ Soft ❑ Firm ❑ Pellets ❑ Other: _______________________

Average Fluid Intake: How many 8oz cups per day: _______________ ; How much of that is caffeinated: ______________

New Heights

PHYSICAL THERAPY ✚

Name: ______________________________ Date:_________________ Date of Birth:______________ Age:______

13) Occupation:____

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

14) 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______________________________________

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

❑ X-ray ❑ MRI ❑ CT Scan
❑ Bone Scan ❑ Arthrogram ❑ Lab Tests
❑ Urine Test ❑ Bowel Test
Results: _____________________________________

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

____

____

____

____

____

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

____

____

18) How would you rate your general health?

❑ Excellent ❑ Good ❑ Average
❑ Fair ❑ Poor

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

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

20) 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?

____

21) Patient Goals:

____

____

22) 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%