



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: _____

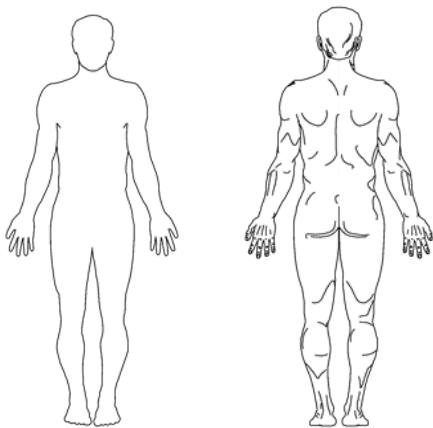
Nickname: _____

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 While lifting
 Car Accident A fall
 Trauma At work
 Overuse Dental
 Degenerative Process
 During recreation/sports
 Other _____

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

New Heights

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%

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: _____

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New Heights

PHYSICAL THERAPY +

Worker's Compensation:

Occupation/Job Title (current): _____
 Company Name: _____
 Supervisor: _____
 Company Phone Number: _____
 Length of Employment: Years/Months: _____

Employer: _____
 Supervisor Phone number: _____
 Fax number: _____

Insurance Information:

Insurance Company: _____
 Adjustor: _____
 Attorney: _____

Claim Number: _____
 Phone Number: _____
 Phone Number: _____

Referring Medical Doctor: _____
 Clinic: _____
 Date of Next Visit: _____
 MD ordered Work Status:

- Full Time
- Part Time
- Full Time Modified
- Part Time Modified
- Not working: Duration _____

MD ordered Work Modifications:

- Lifting restrictions: _____
- Standing restrictions: _____
- Sitting restrictions: _____
- Other: _____

Hours: _____
 Main Job Duties:

Amount lifted daily: _____

- Min weight: _____
- Max weight: _____

Equipment/vehicles used: _____

Frequency:

	N/A	Rare (0-33% of day)	Occasional (34-66%)	Frequent (67-100%)
Lifting floor to waist				
Lifting waist to shoulder				
Lifting shoulder to overhead				
Sitting				
Standing				
Walking				
Squatting				
Crawling				
Climbing				