

# Patient Registration Form

West Portland  
Physical Therapy  
Clinic LLC



|                     |  |                               |        |
|---------------------|--|-------------------------------|--------|
| Patient Information |  | Account # :                   |        |
| Name:               |  | Phone:                        |        |
| Address:            |  | Date of Birth:                |        |
| Email:              |  | May we contact you via email? | Yes No |

|                      |                 |
|----------------------|-----------------|
| Employer Information |                 |
| Employer:            | Employer Phone: |

|   |                  |
|---|------------------|
| Guarantor Information                           |                  |
| Guarantor Name:                                 | Guarantor Phone: |
| Guarantor Address: (If different from patient): |                  |

|                               |                          |
|-------------------------------|--------------------------|
| Emergency Contact Information |                          |
| Emergency Contact:            | Emergency Contact Phone: |
| Relationship:                 |                          |

|                        |             |               |               |               |
|------------------------|-------------|---------------|---------------|---------------|
| Injury Information     |             |               |               |               |
| Date of Injury:        | Onset Date: | Work Related? | Auto Related? | Account Type: |
|                        |             |               | - State -     | -             |
| Description of Injury: |             |               |               |               |

|                       |        |
|-----------------------|--------|
| Physician Information |        |
| Referring Physician:  | Phone: |
| Primary Physician:    | Phone: |
| Other Physician:      | Phone: |

|                            |               |         |                 |             |
|----------------------------|---------------|---------|-----------------|-------------|
| Primary Policy Information |               |         |                 |             |
| Name/Address of Insurance  | Policy / ID # | Group # | Name of Insured | Insured DOB |
|                            |               |         |                 |             |
|                            |               |         | Effective Dates | -           |

|                              |               |         |                 |             |
|------------------------------|---------------|---------|-----------------|-------------|
| Secondary Policy Information |               |         |                 |             |
| Name/Address of Insurance    | Policy / ID # | Group # | Name of Insured | Insured DOB |
|                              |               |         |                 |             |
|                              |               |         | Effective Dates | -           |

I certify that all of the information provided herein is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



|                    |                             |
|--------------------|-----------------------------|
| <b>Name:</b> _____ | <b>Date of Birth:</b> _____ |
|--------------------|-----------------------------|

**NOTIFICATION OF PATIENT RESPONSIBILITY**

West Portland Physical Therapy Clinic, LLC ("WPPTC") verifies your benefits with your insurance carrier but does not guarantee any information given to us regarding benefits, authorization, or network plan. We request that you check with your health plan for a complete understanding of what will be billed to you.

If the information provided by your insurance company or by you is not accurate or the insurance company changes its coverage, you will be responsible for payment for services.

Based upon the information that your insurance company quoted to us, your benefits are as follows:

|                                   |    |                      |   |                    |    |
|-----------------------------------|----|----------------------|---|--------------------|----|
| <b>Deductible:</b>                | \$ | <b>Co-Insurance:</b> | % | <b>Co-Payment:</b> | \$ |
| <b>Benefit Description:</b> _____ |    |                      |   |                    |    |

**FINANCIAL RESPONSIBILITY and ASSIGNMENT OF BENEFITS**

I understand that insurance billing is provided as a courtesy and that I am financially responsible to West Portland Physical Therapy Clinic, LLC for all charges arising from my treatment. It is my responsibility to notify WPPTC of any changes in my health care coverage. While WPPTC verifies benefits with my health plan, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies received by me.

I authorize direct payment from my health insurance plan to WPPTC for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.

**CANCELLATION POLICY**

We are entering into a cooperative partnership with you and your physician to help you attain your maximal rehabilitation goals. We understand that circumstances may arise requiring you to cancel your scheduled appointment. However, cancellations have a serious impact on the clinic. If you need to cancel an appointment on Monday, you must notify us by 4:00 pm on Friday to avoid the cancellation fee.

**A \$35.00 fee will be charged to your account if you cancel with less than 24 hours notice.**

**NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for WPPTC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

**CONSENT FOR TREATMENT and RELEASE OF INFORMATION**

I am aware of my diagnosis and wish to receive treatment from WPPTC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to WPPTC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize WPPTC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

**I certify that I have read this agreement and my signature indicates my understanding and consent.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

It is very important for us to stay in touch with your physician. Please provide us with the date of your next appointment.

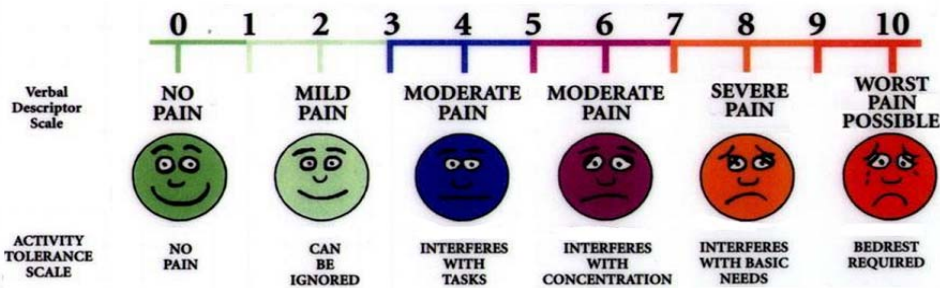
**Next Physician Appointment:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

If you do not have an appointment set, please let us know when you have made your next appointment.

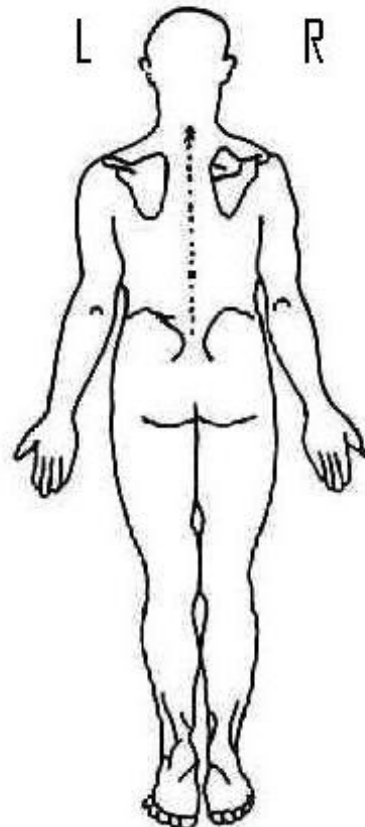
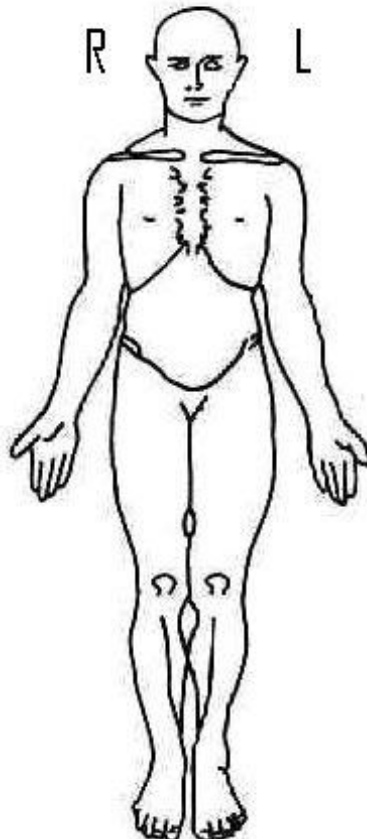
## UNIVERSAL PAIN ASSESSMENT TOOL

Please Circle the Description of your pain in the past week. Circle both your best level of pain and your worst level of pain.



### WHERE IS YOUR PAIN?

Please mark the area of your pain on the drawings below.



# Medical History

West Portland  
Physical Therapy  
Clinic LLC



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Have you had surgery for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_ Date: \_\_\_\_\_

## Please list current medications:

Anti-inflammatories: \_\_\_\_\_

Muscle Relaxers: \_\_\_\_\_

Pain Medication: \_\_\_\_\_

Other: \_\_\_\_\_

## Have you seen or had any of the following for your current complaint: (Check if yes)

|                    |       |                 |       |           |       |
|--------------------|-------|-----------------|-------|-----------|-------|
| Primary Physician  | _____ | Massage Therapy | _____ | CT Scan   | _____ |
| Neurologist        | _____ | Accupuncture    | _____ | EMG       | _____ |
| Orthopedist        | _____ | X-Rays          | _____ | Bone Scan | _____ |
| Physical Therapist | _____ | MRI             | _____ | Other     | _____ |

## Do you now have or have you ever had one of the following?

|                                    | Now   | Past  |                      | Now   | Past  |
|------------------------------------|-------|-------|----------------------|-------|-------|
| Asthmas, Bronchitis, or Emphysema  | _____ | _____ | Cancer               | _____ | _____ |
| Shortness of Breath / Chest Pain   | _____ | _____ | Arthritis            | _____ | _____ |
| Heart Disease or Angina            | _____ | _____ | Stroke / TIA         | _____ | _____ |
| Heart Attack or Surgery            | _____ | _____ | Diabetes             | _____ | _____ |
| High Blood Pressure                | _____ | _____ | Gout                 | _____ | _____ |
| Do You Have a Pacemaker?           | _____ | _____ | Anemia               | _____ | _____ |
| Blood Clot or Emboli               | _____ | _____ | Allergies            | _____ | _____ |
| Infectious Diseases                | _____ | _____ | Osteoporosis         | _____ | _____ |
| Vision or Hearing Problems         | _____ | _____ | Hernia               | _____ | _____ |
| Thyroid or Goiter Trouble          | _____ | _____ | Weakness             | _____ | _____ |
| Numbness or Tingling               | _____ | _____ | Ear Ringing          | _____ | _____ |
| Dizziness or Fainting              | _____ | _____ | Weight Loss          | _____ | _____ |
| Metal in Body or Surgical Implants | _____ | _____ | Weight Gain          | _____ | _____ |
| Joint Replacement                  | _____ | _____ | Neck Injury          | _____ | _____ |
| Sleeping Problems or Difficulties  | _____ | _____ | Back Injury          | _____ | _____ |
| Bowel or Bladder Problems          | _____ | _____ | Knee Injury          | _____ | _____ |
| Emotional / Psychological Problem  | _____ | _____ | Hand Injury          | _____ | _____ |
| Do You Smoke?                      | _____ | _____ | Elbow Injury         | _____ | _____ |
| Are you currently pregnant?        | _____ | _____ | Shoulder Injury      | _____ | _____ |
|                                    |       |       | Ankle or Foot Injury | _____ | _____ |

## Please list any past surgeries that you have had and the date:

Are you aware of your current diagnosis? Yes \_\_\_\_\_ No \_\_\_\_\_

## What are your expectations and goals of treatment?

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Women's Health / Pelvic Floor Questionnaire

West Portland  
Physical Therapy  
Clinic LLC



|                    |                             |
|--------------------|-----------------------------|
| <b>Name:</b> _____ | <b>Date of Birth:</b> _____ |
|--------------------|-----------------------------|

Please answer the following questions so that we can best help you manage your concerns.

Do you now or have you had a history of the following?

|                     | NOW   | PAST  |                | NOW   | PAST  |
|---------------------|-------|-------|----------------|-------|-------|
| Bladder Infections  | _____ | _____ | Constipation   | _____ | _____ |
| Painful Intercourse | _____ | _____ | Abdominal Pain | _____ | _____ |
| Menopause           | _____ | _____ | Endometriosis  | _____ | _____ |
| Pelvic Pain         | _____ | _____ | STD            | _____ | _____ |

Explain the above responses: \_\_\_\_\_

|  | ALWAYS | SOMETIMES | NEVER |
|--|--------|-----------|-------|
| 1. Do you have trouble making it to the toilet on time?    | _____  | _____     | _____ |
| 2. Do you lose urine or stool when you have a strong urge? | _____  | _____     | _____ |
| 3. Do you lose urine or stool with any of the following?   |        |           |       |
| Coughing or Sneezing                                       | _____  | _____     | _____ |
| Laughing   | _____  | _____     | _____ |
| Lifting  | _____  | _____     | _____ |
| Exercise such as running/jumping                           | _____  | _____     | _____ |
| Minimal exercise such as walking                           | _____  | _____     | _____ |
| Intercourse  | _____  | _____     | _____ |
| Leakage unrelated to any specific cause                    | _____  | _____     | _____ |

Other, Please Explain \_\_\_\_\_

- |  |   |
|--|---|
| <p>4. Is your clothing:</p> <p style="padding-left: 20px;"> <input type="checkbox"/> wet a few drops<br/> <input type="checkbox"/> wet underwear<br/> <input type="checkbox"/> wet outer clothing<br/> <input type="checkbox"/> wet floor         </p> | <p>5. For protection do you use:</p> <p style="padding-left: 20px;"> <input type="checkbox"/> sanitary pads      <input type="checkbox"/> Number used daily<br/> <input type="checkbox"/> tissue paper      <input type="checkbox"/> Number used daily<br/> <input type="checkbox"/> adult Depends      <input type="checkbox"/> Number used daily         </p> |
| <p>6. At each change of your protection, are they:</p> <p style="padding-left: 20px;"> <input type="checkbox"/> damp?<br/> <input type="checkbox"/> wet?<br/> <input type="checkbox"/> saturated?         </p>   | <p>7. How often do you urinate:</p> <p style="padding-left: 20px;"> <input type="checkbox"/> During the day?<br/> <input type="checkbox"/> At night?         </p>   |
| <p>8. Is the volume of urine you usually pass</p> <p style="padding-left: 20px;"> <input type="checkbox"/> large?<br/> <input type="checkbox"/> average?<br/> <input type="checkbox"/> small?         </p>   | <p>9. Do you have urinary urgency often but are only able to pass a small amount of urine _____?</p>  |
10. Do you empty your bladder frequently before you experience the urge to urinate just so you can stay dry \_\_\_\_\_?
11. How many glasses of fluid do you drink a day \_\_\_\_\_?  
How many are caffeinated \_\_\_\_\_?
12. How often do you have a bowel movement \_\_\_\_\_?
13. Can you delay going to the bathroom when you have an urge \_\_\_\_\_?
14. Do you have trouble initiating a urine stream \_\_\_\_\_?
15. Can you stop the flow of urine \_\_\_\_\_?

# Women's Health / Pelvic Floor Questionnaire

West Portland  
Physical Therapy  
Clinic LLC



|             |                      |
|-------------|----------------------|
| Name: _____ | Date of Birth: _____ |
|-------------|----------------------|

Previous treatment and effectiveness:

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List surgeries and dates:

---

---

Any current exercise program:

---

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## Birth History

Number of pregnancies: \_\_\_\_\_

Number of deliveries: \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Please indicate areas where you have pain:

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Rate the severity of your problem from 1-10 (10 being the worst): \_\_\_\_\_

Please describe any activities or things that you cannot do because of your problem:

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Do you have any other concerns or problems not asked?

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# Consent Form Internal Pelvic Floor Evaluation

West Portland  
Physical Therapy  
Clinic LLC



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

In order to fully understand the scope of your individual diagnosis there is some very important information your therapist needs.

Please be brief in your answers. If your physical therapist needs you to expand upon your answers she will ask you privately.

- |  | Yes          | No           |
|--|--------------|--------------|
| 1. Are you currently sexually active?<br>If "no", have you been sexually active in the past? | ____<br>____ | ____<br>____ |
| 2. Do you have any communicable diseases?<br><br>If yes, please describe _____               | ____         | ____         |
| 3. Has there been any sexual abuse in your past  | ____         | ____         |
| 4. Have you had difficulty with past vaginal exams?  | ____         | ____         |

I give / deny my consent for my therapist to do a vaginal/rectal examination for the purpose of evaluating my condition and determining therapeutic treatment.  
(please circle)

1. I understand that I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of having a second person present in the room during this procedure and I refuse / choose this option.  
(please circle)
4. I have read this consent form and understand its terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_