

Kwan Yin Healing Arts Center East

3115 NE Sandy Blvd, Suite 231, Portland, OR 97232

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Physical Therapy Intake



Thank you for scheduling with us, we strive to provide the best possible integrative care for our clients. Here at the clinic we have a team of Naturopathic Doctors, Oriental Medical Practitioners, Licensed Acupuncturists, Massage Therapists and Physical Therapists. During your initial evaluation your practitioner will do their best to do a thorough evaluation and give you a treatment plan. You can assist us in that by making sure you have fully completed the intake paperwork enclosed. The advantage of the integrative office is that there are many modalities that can provide input should any of us find the need for assistance.

Please be aware that we ask patients to give us **48 hour notice** if they need to reschedule or cancel an appointment. Late cancellation or missed appointments incur a \$45.00 fee or greater, as we are unable to reschedule the appointment with another patient without sufficient notice.

It will be a pleasure to support you on your path towards wellness.

Informed Consent and Request for Physical Therapy Services

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Patrick Geraghty DPT, Elsa Mitchell DPT having had the opportunity to discuss the potential benefits, risks and hazards involved.

I _____ hereby request and consent to examination and treatment with the above mentioned providers.

I understand that I have the right to ask questions and discuss to my satisfaction with the *above* mentioned providers:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Physical Therapy evaluation and treatment may include, but are not limited to:

- Physical Exam: general, musculoskeletal, orthopedic and neurological assessments)
- Self Care Techniques: explanation of rehab diagnosis, concepts of exercise/aerobic programs, stress management, postural education, ergonomics, body mechanics, functional balance strategies, home program, pacing, ice/heat, sleep strategies, equipment use, and skin care.
- Therapeutic Exercise: strengthening, stretching, stabilization, resistance training, and aerobic training.
- Neuromuscular Re-education: restoring normal motor firing patterns, proper isolation of muscle contractions, inhibition of over active muscle groups.
- Functional Therapeutic Activities: gait training, balance training, stair training, and equipment/device training.
- Manual Therapy: soft tissue mobilization, deep tissue mobilization, muscle energy technique, joint mobilizations to spine and joints, pregnancy massage (to relieve muscular discomfort associated with pregnancy), strain/counter strain technique, functional indirect technique and CranioSacral therapy).
- Pelvic floor treatment: internal evaluation, neuromuscular re-education, biofeedback, electrical stimulation, internal tissue mobilization, bladder and bowel training, urge control techniques, frequency reduction training.
- Counseling (including but not limited to visualization for improved lifestyle strategies).

Notices:

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider of these conditions.

Please INITIAL the following:

_____ I understand that the above mentioned providers are not licensed to prescribe any medication.

_____ I understand that above mentioned providers are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above mentioned providers and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the above mentioned providers explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

Printed Name of Patient

Signature of Patient

Date

Printed Name of Guardian

Signature of Guardian

Date

Basic Information

Name _____ Date _____

Address _____

City _____ State _____ Zip code _____

Telephone# (home) _____ (work) _____

(cell) _____ Email Address _____

Age _____ Date of Birth _____ Gender _____

Relationship Status: Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone Roommates

Occupation _____ Hours per week _____ Retired _____

How did you hear about our clinic? _____

Emergency Contact: Name _____ Relationship _____

Phone _____

Are you currently under the care of a medical professional? Y N

If yes, whom and where from? _____

If no, when and where did you last receive medical or health care and for what reason? _____

What are your most important health concerns? List in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

Please answer the following questions to the best of your ability:

In your opinion, what do you think caused your symptoms:

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Prior treatment for this condition (please check all that apply):

- None MD Chiropractic Naturopath Acupuncture Physical Therapy
 Exercise Nutrition Medication Surgery: What. _____
When _____ Imaging, Please list results: _____

If you have a pain please check condition(s) and location(s):

- | | |
|---|---|
| <input type="radio"/> Burning | <input type="radio"/> Head/neck |
| <input type="radio"/> Dull Ache | <input type="radio"/> Mid-back |
| <input type="radio"/> Sharp | <input type="radio"/> Shoulder |
| <input type="radio"/> Sharp with movement | <input type="radio"/> Elbow/Wrist |
| <input type="radio"/> Throbbing | <input type="radio"/> Low Back |
| <input type="radio"/> Radiating | <input type="radio"/> Pelvis/Buttock Region |
| <input type="radio"/> Numbness/tingling | <input type="radio"/> Hip |
| <input type="radio"/> Knee | |
| <input type="radio"/> Ankle | |

Other: _____ Describe: _____
 Other: _____ Describe: _____

Pain Intensity (Mark which number that represents your pain):

No Pain 0 1 2 3 4 5 6 7 8 9 10 Highest Pain

Frequency of Pain; Constant Frequent Occasional Intermittent

Since onset, pain is: Better Same Worse

Symptoms are most present: Upon waking AM Mid-day Afternoon Evenings
 Night Varies, please explain: _____

Symptoms are worse with/Aggravating factors:

- Activity
- Bending
- Lying
- Reaching
- At rest
- Sitting
- Standing
- Transitions
- Cough/Sneeze
- Stress/Anxiety
- other: _____

Symptoms are better with/Easing Factors:

- Activity
- Rest
- Positioning
- Lying Down
- Walking
- Heat
- Ice
- Medications
- Massage
- No Relief
- Other: _____

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Functional Status:

Describe any activities that are **limited** due to the condition for which you are seeking therapy:

What activities are you **unable** to do currently that you would like to return to as a result of therapy: _____

What do you do for exercise? _____

Frequency/Duration: _____

Work Information:

Occupation: _____

Physical Demands of Job: Light Medium Heavy

Work Status: Full Duty Light Duty Part Time Disability Not Working
 Retired

Medical History: (Please check all that apply)

- | | | | | |
|---|--|--|------------------------------------|--------------------------------|
| <input type="radio"/> Diabetes | <input type="radio"/> Heart Disease | <input type="radio"/> Stroke | <input type="radio"/> Arthritis | <input type="radio"/> Asthma |
| <input type="radio"/> Hypertension | <input type="radio"/> Heart Attack | <input type="radio"/> Thyroid Disease | <input type="radio"/> Pneumonia | <input type="radio"/> COPD |
| <input type="radio"/> High Cholesterol | <input type="radio"/> Irregular heartbeats | <input type="radio"/> Cancer- List type: | <input type="radio"/> Tuberculosis | <input type="radio"/> HIV/AIDS |
| <input type="radio"/> Glaucoma | <input type="radio"/> Seizures | <input type="radio"/> Dementia | <input type="radio"/> Emphysema | <input type="radio"/> Anxiety |
| <input type="radio"/> Intestinal Problems | <input type="radio"/> Blood clots | <input type="radio"/> Fibromyalgia | <input type="radio"/> Depression | |

Congestive Heart failure Peripheral vascular disease Bladder/bowel problems

Other _____

Medication; please list all medications and supplements you are currently taking:

Please list any allergies: _____
