ELEMENT
wellness & sports rehabilitation

5757 S Macadam Ave, Ste 150, Portland, OR 97239
T {503} 445 7999 F {503} 445 7997
ElementWellnessPDX.com

Notification of Patient Responsibility

____**Pay at Time of Service Agreement:** ___Physical Therapy ___Chiropractic

You must pay in full for all services rendered. As long as you pay in full upon each visit and keep your balance at zero, you will receive a discount from our billed charges. A written copy of the fees for specific services provided at Element Wellness & Sports Rehabilitation is available upon request. The cost per visit is dependent upon the specific modalities/treatment performed and all fees are subject to change. In the event that Element Wellness & Sports Rehabilitation increases the pay at time of service fees, notification will be clearly posted in the office as to the new fee schedule and the date the increase will take effect. We also offer a package discount on physical therapy services. Please inquire with front office staff if interested.

____**Insurance Billing Agreement:** ___Physical Therapy ___Chiropractic

We check your benefits online in order to collect appropriately at the time of service. You are ultimately responsible for any account balances not covered by your insurance carrier. Please contact your insurance company for detailed benefit information. If you have questions about your benefits, our staff is happy to answer questions to the extent to which we know your benefits.

☐ Printed benefit summary given to patient ☐ No insurance printout available

Please verify that you understand your financial responsibility by signing and dating below.

Printed name of patient: _____

Signature of patient/legal representative: _____ Date: _____

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Financial Policies

Element Wellness & Sports Rehabilitation welcomes you as a new patient. If you have any questions regarding our office policies, please ask any of our front desk staff for clarification prior to initialing.

Please initial each of the following:

_____**Cancellation Policy:** We require 24-hour notice for cancellations and rescheduling of appointments. (example: if you have an appointment at 9am on Monday, you must call by 9am Friday to cancel and avoid paying a fee). If your appointment falls on a Monday or after a Monday holiday, you must cancel the weekday prior. **CANCELLATIONS CANNOT BE DONE VIA EMAIL.** If you fail to cancel 24 hours prior to the appointment, a charge of $80 will be assessed to you, due prior to the start of your next visit. You will be personally responsible for the fee; it cannot be billed to your insurance company. Should you choose to take advantage of our package pricing on physical therapy, you will forfeit a full visit from your package. If three appointments are cancelled without 24-hour notice within one calendar year, we reserve the right to discontinue care. In this case, you may be eligible to continue care at our Pay at Time of Service rate and will be charged the full cost of the appointment for any further late cancellations.

_____**Tardiness Policy:** The appointments you schedule with your provider are your designated treatment times. As a result, tardiness will impact your care and must be avoided as much as possible. Appointments will not be extended to compensate for tardiness. After 3 tardy occurrences, a $40 fee will be charged if you are 15 minutes late and an $80 fee will be charged if you are 30 minutes late. This fee cannot be charged to insurance and must be paid on the date of your treatment. If you are 15 minutes late or more, you are still responsible for the full price of your appointment.

_____**Collection Policy:** We charge 3% monthly interest for all unpaid balances over 90 days. If an account is over six months delinquent, it will be subject to legal collection with an added 40% collection fee. The key to avoid this situation is **communication**. WE WILL WORK WITH YOU! Just talk to us. If an account is sent to collections, your payment must then be paid directly to the collection agency.

_____**Returned Check Policy:** Element Wellness & Sports Rehabilitation has a $35 fee for all returned checks.

Please verify that you understand all of our office policies by signing and dating below.

_____

Printed Name of Patient

_____ _____

Signature of Patient/Parent/Guardian/Legal Representative Date

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Consent to Use and Disclose Protected Health Information for Treatment, Payment or Healthcare Operation Form

I _____ _____ understand that as a part of my healthcare,
(Name of Patient) (Date of Birth)

Element Wellness & Sports Rehabilitation originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and history, public health and home health, as well as any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnoses and referral information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment and healthcare operations. Element Wellness & Sports Rehabilitation is not required to agree to the restrictions requested.

This consent remains in effect unless I give written notice to revoke. I understand that my refusal to give permission will not influence the services I received.

I wish to have the following restriction to the use and disclosure of my health information:

_____

_____

_____

_____

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date

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Informed Consent for Physical Therapy

I, _____ _____, hereby request and consent to the
(Name of Patient) (Date of Birth)
performance of the physical therapy procedures, including examination tests, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by my Physical Therapist who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for my Physical Therapist at Element Wellness and Sports Rehabilitation.

I have had an opportunity to discuss with my Physical Therapist and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

By signing below I state that I have weighed the risks involved in undergoing treatment and have, myself decided that is in my best interest to undergo the physical therapy treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

I understand that I can provide written notification to remove my consent for treatment at any time.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date

_____ _____
Translated By Date

ELEMENT
wellness & sports rehabilitation

Pelvic Floor Questionnaire

Name: _____ Date: _____

Age:_____ Pronouns: _____

I identify my sex as (select one): □Female □Male □Intersex □MtF Female □FtM Male □No Gender

Thank you for taking the time to fill out this questionnaire. These questions will help your physical therapist understand the full scope of your health to better treat you. Please answer to the best of your ability. If you have any questions or concerns, leave the section blank and ask your therapist.

If any section does not apply to you, simply leave it blank.

Chief Complaint

Please describe your symptoms, what brings you in today?

_____

_____

When did your symptoms begin? _____

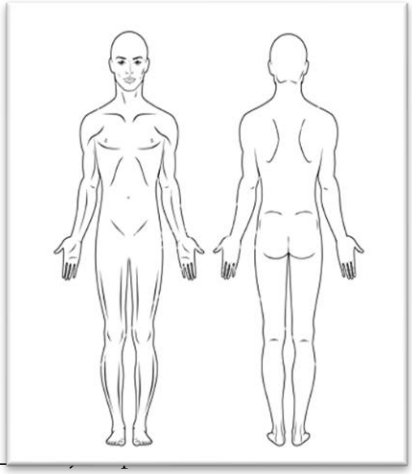
Do your symptoms **radiate** elsewhere? □ No □ Yes: _____

Did your symptoms begin **gradually** or **suddenly**? _____

Have your symptoms gotten **better/worse/remained the same**? _____

If you have pain/discomfort, please answer the following two questions (skip both if not):

1. What **type** of pain/discomfort do you have?
   - □ pain □ numbness □ tingling □ stiffness
   - □ soreness □ swelling □ weakness
2. How would you **describe** the pain/discomfort that you have?
   - □ burning □ dull □ throbbing □ superficial □ "pins & needles"
   - □ shooting □ stinging □ tingling □ deep □ uncomfortable
   - □ aching □ sharp □ intense □ numb



How **often** do you experience your symptoms?

□ Occasionally (0-25%) □ Intermittently (26-50%) □ Frequently (51-75%) □ Constantly (76-100%)

Please rate the **intensity** of your **main area (specify here:** _____ at each state:

WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10

|----------Mild----------| |----------Moderate----------| |----------Severe----------|

Which activities make your symptoms **worse** (i.e. sitting, sexual activity, etc.) ?

_____

_____

Which activities make your symptoms **better** (i.e. rest, pain medication, heat, etc.)?

_____

_____

OB History

Marital status: Married / Single / Widowed / Divorced / Significant Other

How many pregnancies have you had? Total: _____ Vaginal Deliveries: _____ Cesarean Sections: _____

Age(s) of Children: □ 0-5 (how many? ___) □ 6-9 (how many?___) □ 10-17 (how many?___) □ Older than 18 (how many?___)

Complications (check all that apply): □ Baby larger than 8 lbs. □ Forceps □ Severe tearing □ Episiotomy □ None

□ Other (please explain):_____

Did you have urinary leakage during or immediately after your pregnancy? □ Yes □ No □ Don't Remember

Menstrual history (check all that apply): □ Pre-menopause □ Peri-menopause □ Post-menopause □ Pain with menses

□ Irregular cycles □ Post-partum (how many weeks?_____)

Are you currently pregnant? □ Yes □ No □ Possibly

What type of birth control do you use? □ none □ condom □ pill □ IUD □ implant □ ring □ other

Menstrual History

Do you experience

Painful periods □Yes □ No

Regular cycles □Yes □ No □ Don't know b/c on birth control

Pain with tampon insertion □Yes □ No

Pain with ovulation □Yes □ No

Bladder Habits

Number of times you urinate during the day? □ 3-5 □ 6-9 □ 10-13 □ >13

Number to times you urinate after going to bed: □ 0 □ 1-2 □ 2-3 □ >3

How many glasses do you drink each day (One glass is 8 oz or one cup):

Clear liquids: □ 1-2 □ 2-3 □ 3-4 □ 4-5 □ >5

Caffeine: □ 0 □ 1-2 □ 2-3 □ 3-4 □ 4-5 □ >5

Alcohol (each week): □ 0 □ 1-2 □ 2-3 □ 3-4 □ 4-5 □ >5

Number of urinary leakages during the day: □ 0 □ 1-2 □ 2-3 □ 3-4 □ 4-5 □ >5

When do you leak urine? (check all that apply)

□Cough/sneeze □On the way to the restroom □No activity changes leakage (constant)

□Hear running water □Exercising □Changing positions

□Jumping □Laughing

□During sleep □During intercourse

□Immediately after voiding □Other: _____

Do you have burning/pain with urination? □ Yes □ No □ Sometimes

Do you have ***bladder*** pain? □ Yes □ No □ Sometimes If yes, is it relieved after voiding? □ Yes □ No

Do you have difficulty starting a stream of urine? □ Yes □ No □ Sometimes

Do you strain to empty your bladder? □ Yes □ No □ Sometimes

Do you feel unable to fully empty the bladder? □ Yes □ No □ Sometimes

Do you have a "falling out" feeling? □ Yes □ No □ Sometimes

Do you have a strong urge to urinate? □ Yes □ No □ Sometimes

Do you restrict your fluid intake due to fear of urinary leakage? □ Yes □ No □ Sometimes

Do you use a form of leakage protection (check all that apply)

□ Pantiliner □ Maxi pad □ Incontinence pad □ Incontinence brief □ None

How many pads do you use per day? _____

Bowel Habits

How many bowel movements do you have each day? □ 0-1 □ 1-2 □ 2-3 □ >3
Most common stool consistency: □ Soft □ Liquid □ Formed □ Constipated
Do you strain to have a bowel movement? □ Yes □ No □ Sometimes
Do you take laxatives/enema regularly? □ Yes □ No □ Sometimes
Do you have pain with bowel movement? □ Yes □ No □ Sometimes
Do you have a strong urge to move bowels? □ Yes □ No □ Sometimes
Do you leak/stain bowel? □ Yes □ No □ Sometimes
Do you have diarrhea often? □Yes □ No □ Sometimes
Do you include fiber in your diet? □ Yes □ No

Sexual Activity

For pelvic health, sexual function is an important component to be addressed. These questions are helpful in creating a complete treatment plan for you. However, please know you may choose not to disclose any portion of the following information.
Sex of partner(s): □ Person(s) with penis □ Person(s) with vagina
Are you currently sexually active? □Yes □ No □ It's complicated

Orgasm, Erectile, Clitoral Function (answer all that apply to you)

Do you have pain with penetration? □Yes (□ vaginal □ rectal) □ No
Do you have pain with manual intercourse? □Yes □ No □ Sometimes
Do you have pain with oral intercourse? □Yes □ No □ Sometimes
Do you need lubrication? □Yes □ No □ Sometimes
Are you able to achieve an orgasm? □Yes □ No □ Sometimes
Pain with orgasm? □Yes □ No □ Sometimes
Arousal without completion? □Yes □ No □ Sometimes
Do you have pain after sex? □Yes □ No □ Sometimes
Premature ejaculation? □Yes □ No □ Sometimes
Painful ejaculation? □Yes □ No □ Sometimes
Difficulty with erection? □Yes □ No □ Sometimes
Low libido/lack of desire? □Yes □ No □ Sometimes
Do you feel safe in your current relationship? □Yes □ No
Have you ever been forced to engage in sexual activity against your will? □Yes □ No
Do you have a history of STD? □Yes □ No
What else would be helpful for us to know related to your care?

_____

_____

Treatment History

Have you received medical attention for your **primary complaint**? □ Yes □ No
If yes, what is the name of the **provider** who treated you? When did you **first seek medical attention** for your primary complaint? _____
What **diagnoses/treatment** was given for your primary complaint?

_____

How many times were you treated? Date of last treatment? _____
Did symptoms **get better/worse/remained the same** with past treatment? _____

Were **x-rays/CT scan/MRI/ultrasound images** taken? □ Yes □ No
If yes, what were the results? _____

Review of Systems

Please check **all of the symptoms** that you are **CURRENTLY** experiencing. If none apply, check "None".

CONSTITUTIONAL SYMPTOMS:

□ General fatigue
□ Fever
□ Malaise
□ Headaches
□ Unintentional weight loss
□ Loss of appetite
□ Loss of sleep (due to pain)
□ Loss of coordination/balance
□ Dizziness
□ Night sweats
□ Chills
□ None

EYES:

□ Blurred vision
□ Pain behind the eyes
□ Crossed eyes
□ Dry eyes
□ Double vision
□ Nystagmus (involuntary eye movement)
□ Loss of vision
□ Poor vision at night
□ None

EARS/NOSE/THROAT:

□ Difficulty swallowing
□ Bleeding gums
□ Ear discharge
□ Loss of hearing
□ Hoarseness
□ Hay fever
□ Nosebleeds
□ Persistent cough
□ Ringing in ears
□ Sinus problems
□ Earache/infection
□ Chronic sinusitis
□ None

RESPIRATORY:

□ Difficulty breathing
□ Asthma
□ Bronchitis
□ Coughing up blood
□ None

CARDIOVASCULAR:

□ High blood pressure
□ Low blood pressure
□ Heart attack
□ Chest pains
□ Angina
□ Stroke
□ Deep vein thrombosis
□ Poor circulation
□ Irregular heartbeat
□ Rapid heartbeat
□ Swollen ankles/feet
□ Varicose veins
□ None

GASTROINTESTINAL:

□ Bloating
□ Constipation
□ Diarrhea
□ Vomiting
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Vomiting blood
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Ulcer
□ Stomach pain
□ Heartburn
□ Abdominal pain
□ Hepatitis
□ None

GENITOURINARY:

□ Difficulty urinating
□ Kidney stones
□ Painful urination
□ Lack of bladder control
□ Blood in urine
□ Bladder infection
□ Frequent urination
□ Kidney disorder
□ None

MUSCULOSKELETAL:

□ Neck pain
□ Jaw pain
□ Shoulder pain
□ Arm/elbow pain
□ Upper back pain
□ Mid back pain
□ Low back pain
□ Wrist/hand pain
□ Hip/upper leg pain
□ Knee/lower leg pain
□ Ankle/foot pain
□ Joint swelling/stiffness
□ Osteoarthritis
□ Muscle fatigue
□ Muscle spasm
□ None

SKIN:

□ Changes in mole(s)
□ Hives
□ Rashes
□ Itching
□ Scars
□ Eczema
□ Sores that don't heal
□ Bruises
□ None

BLOOD/LYMPH:

□ Diabetes Type I
□ Diabetes Type II
□ HIV/AIDS
□ Rheumatoid arthritis
□ Autoimmune disease
□ Cancer
□ Tumor
□ Systemic lupus
□ None

ALLERGIES:

□ Dairy
□ Dander/dust
□ Gluten
□ Nuts
□ Pollen
□ Wheat
□ Penicillin
□ Bee sting
□ Grass
□ Shellfish
□ None
□ Other: _____

FEMALE:

□ Breast lump
□ Breast discharge
□ Vaginal discharge
□ Bleeding between periods
□ Extreme menstrual pain
□ Abnormal pap smear
□ Abnormal menses
□ Menopause
□ Contraception use
□ Hot flashes
□ Pregnancy
□ Urinary incontinence
□ None
□ Other: _____
_____

Occupational History

What is your **current** job occupation? _____

How long have you worked at this job? _____

□ part time □ full time

How many **weekly hours** do you currently work? _____

How would you describe your work activity level?

□ Sedentary □ Light □ Moderate □ Heavy □ Very heavy

Have you missed work due to pain/discomfort? □ Yes □ No If yes, how long? _____

Wellness History

What is your current weight? _____ What is your current height? _____

Do you have a primary care physician? □ Yes □ No When was your **last** physical exam? _____

Do you smoke cigarettes/tobacco use? □ Yes □ No If yes, how many packs **per day**? _____

How many hours of sleep do you currently get **per night** on average? _____

Do you consider your diet healthy? □ Yes □ No If no, why? _____

How many times per week do you exercise? _____

What kind of **exercise** do you participate in (check all that apply)?

□ Walking	□ Dancing	□ Basketball	□ Rock climbing
□ Running	□ Plyometrics	□ Baseball	□ TRX Suspension
□ Aerobic classes	□ Pilates	□ Soccer	□ Calisthenics
□ Cross Fit	□ Spinning classes	□ Hockey	□ Nautilus
□ Bicycling	□ Yoga	□ Football	□ None
□ Free weights	□ Rowing	□ Tennis	□ Other: _____
□ Martial arts	□ Swimming	□ Golf	_____

Personal Health History

Please check **all the symptoms** that you have had **in the past**.

□ Headaches	□ General arthritis	□ Asthma	□ Liver/gall bladder disorder
□ Jaw pain	□ Chest pain	□ Excessive thirst	□ Kidney disorders
□ Neck pain	□ Abdominal pain	□ Dermatitis/eczema/rash	□ Kidney stones
□ Upper back pain	□ Heart attack	□ Allergies	□ Loss of bladder control
□ Mid back pain	□ Angina	□ Miscarriage	□ Frequent urination
□ Low back pain	□ High blood pressure	□ Hysterectomy	□ Bladder infection
□ Low back stiffness	□ High cholesterol	□ Contraception use	□ Prostate problems
□ Shoulder pain	□ Stroke	□ Hormonal replacement	□ Constipation
□ Arm/elbow pain	□ Ulcer	□ General fatigue	□ Painful urination
□ Wrist pain	□ Earache/infection	□ Diabetes	□ Smoking/tobacco use
□ Hand pain	□ Dizziness	□ Loss of appetite	□ Cancer
□ Hip/upper leg pain	□ Epilepsy	□ Depression	□ HIV/AIDS
□ Ankle/foot pain	□ Muscular incoordination	□ Abnormal weight loss/gain	□ Tumor
□ Leg numbness/tingling	□ Visual disturbances	□ Drug/alcohol dependency	□ None
□ Joint swelling/stiffness	□ Chronic sinusitis	□ Hepatitis	□ Other:
			_____

Please describe the **treatment you received** for the above conditions and if any of the conditions are unresolved:

_____

_____

_____

Please list all the **surgical procedures** you have had, including the dates they were performed and other times you have been hospitalized:

_____

_____

_____

Medication/Vitamin Supplementation

Please list all prescription and over-the-counter medications and nutritional/herbal supplements you are currently taking:

_____

_____

_____

Goals for Treatment

Please indicate what your personal goals for treatment are:

_____

_____

_____

Family Health History

Please indicate below which of the following conditions your family has a history of and/or an immediate family member has experienced:

□ Drug/alcohol dependency	□ Diabetes	□ Parkinson's disease	□ Multiple sclerosis
□ Lung disease	□ Blood disorder (e.g. anemia)	□ Huntington's disease	□ Osteoporosis
□ Stroke	□ Heart disease	□ Thyroid problems	□ Prostate issues

Family Health History (continued)

□ Bone/joint disorder	□ High blood pressure	□ Kidney disease	□ None
□ Autoimmune disease	□ High cholesterol	□ Hepatitis	□ Other: _____
□ Cancer	□ Migraine headaches	□ Liver disease	_____
□ Depression	□ Osteoarthritis	□ Psychiatric issues	_____

Pelvic Floor Impact Questionnaire – Short Form 7

For each question, place an X in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions in the areas to the right affect the below activities:	***Bladder or Urine***	***Bowel or Rectum***	***Vagina or Pelvis***
1. Ability to do household chores (i.e. cooking, cleaning, laundry)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
3. Entertainment activities such as going to a movie or concert?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
5. Participating in social activities outside your home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
6. Emotional health (i.e. nervousness, depression, etc)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
7. Feeling frustrated?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
TOTALS:			

Scoring the PFIQ-7:

All of the items use the following response scale: Not at all = 0; Somewhat = 1; Moderately = 2; Quite a bit = 3

Obtain the mean value for all of the answered items within the corresponding scale (possible value 0 to 3) and then multiply by (100/3) to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFIQ-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).