Journey to Health PT
Dr. Angela Grenier, PT, DPT, LMT
Journeytohealthpt.com

Journey to Health
PHYSICAL THERAPY

8835 SW Canyon Lane #125
Portland, OR 97225
503-809-2288

New Patient Registration

Patient Name: ____ Today's Date: __________

Date of Birth: __________ Age: ______ Sex: M / F Social Security #: ________ - ______ - _________

Address: ____

Primary Phone: (______) _______ - ___________ ☐ home ☐ cell ☐ work ☐ preferred

Secondary Phone: (______) _______ - ___________ ☐ home ☐ cell ☐ work ☐ preferred

E-mail: ____ ☐ opt-in ☐ opt-out

Employer: ______________________________ Occupation: ______________________________

Primary Physician's Name: _____________________________ Phone: (______) _______ - ___________

Emergency Contact: _________________________________ Phone: (______) _______ - ___________

Address: ____

Next of Kin: ☐ same as emergency ☐ other: ____

Who may we thank for referring you? ____

Payment information

☐ I will pay my balance in full at time of service
☐ I prefer to make payment arrangements prior to services being rendered
☐ I intend to bill insurance (we provide superbill for you to submit for reimbursement):

Name of Insured __________________________ Relationship to Patient: ______________________

Insurance Company: _______________________ Claims Phone: (______) _______ - ___________

Claim #: ________________________________ Representative name: _______________________

Date of collision/work injury: ____________ Other contact info: _________________________

Patient/Guardian Signature: ____ Date: ____________

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Patient Initial Intake

Patient Name: ____ DOB: ______________ Date: ______________

Describe your symptoms: ______________________________
____
____
____

Describe any activities affected by your symptoms:
____
____

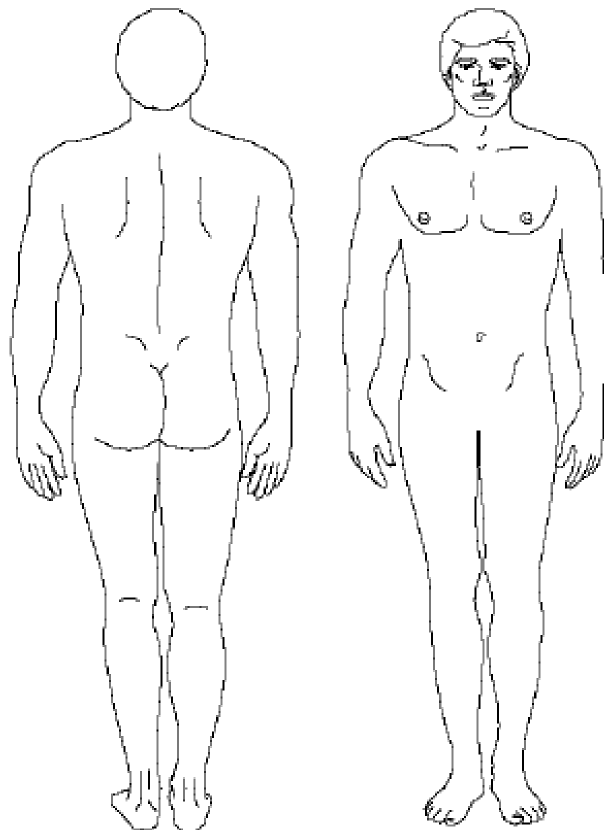
When did your symptoms begin? ______________________
____

Are you symptoms getting worse? ☐ No ☐ Yes
Does it keep you from working? ☐ No ☐ Yes
Does it keep you from sleeping? ☐ No ☐ Yes

Have you seen a chiropractor before? ☐ No ☐ Yes
Are you under the care of a physician? ☐ No ☐ Yes
Name of physician: ________________________________

Please list current medications and reasons for taking them:
____
____

Indicate the location of your symptoms:



Have you ever experienced:	No	Yes	If yes, briefly explain:
☐ broken bone	☐	☐	______________________________
☐ hospitalization/surgery	☐	☐	______________________________
☐ strains/sprains	☐	☐	______________________________
☐ fallen/struck unconscious	☐	☐	______________________________
☐ auto collision/work injury	☐	☐	______________________________

Please list any other health conditions (10 years): ____
____
____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/day ________________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/week ______________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/day ________________
☐ Heavy	☐ Heavy Labor	☐ Stress level	Reason __________________

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Review of Systems

Patient Name: ____ DOB: ______________ Date: ______________

All information will be kept strictly confidential. Your responses will help determine if physical therapy treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please indicate all CURRENT or PAST conditions. To be responsible for your case, we need your complete health history.

C = Current problem P = Past problem

C P Muscle / Joint
- ☐ ☐ Neck pain, stiffness
- ☐ ☐ Pain b/t shoulders
- ☐ ☐ Low back pain
- ☐ ☐ Sciatica
- ☐ ☐ Painful tailbone
- ☐ ☐ Poor posture
- ☐ ☐ Spinal curvature
- ☐ ☐ Foot trouble
- ☐ ☐ Swollen joints
- ☐ ☐ Bursitis

C P Pain
- ☐ ☐ Headache
- ☐ ☐ Eye
- ☐ ☐ Ear
- ☐ ☐ Abdomen
- ☐ ☐ Chest
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Elbows
- ☐ ☐ Forearm
- ☐ ☐ Hand
- ☐ ☐ Hips
- ☐ ☐ Thigh
- ☐ ☐ Knee
- ☐ ☐ Shin
- ☐ ☐ Ankle
- ☐ ☐ Feet

C P Numbness
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Forearm
- ☐ ☐ Thigh
- ☐ ☐ Shin / calf
- ☐ ☐ Feet

C P General
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Concussion
- ☐ ☐ Allergy
- ☐ ☐ Skin rash
- ☐ ☐ Enlarged glands

C P Cardiovascular
- ☐ ☐ Hardened arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heartbeat
- ☐ ☐ Slow heartbeat
- ☐ ☐ Swelling of ankles

C P Gastrointestinal
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Jaundice
- ☐ ☐ Liver trouble
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

C P Genitourinary
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Lose bladder control
- ☐ ☐ Kidney infection
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble

C P WOMEN ONLY:
- ☐ ☐ Congested breasts
- ☐ ☐ Lumps in breast
- ☐ ☐ Menstrual pain
- ☐ ☐ Irregular cycle
- ☐ ☐ Excessive flow
- ☐ ☐ Hot flashes
- ☐ ☐ Menopause

C P Respiratory
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spit up blood

Check any conditions you have presently OR have had in the past:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Pacemaker (or other medical implant): ☐ No ☐ Yes

Pregnant: ☐ No ☐ Yes ☐ Planning

Please list any family history of serious illness (i.e. heart disease, stroke, cancer, diabetes):

____
____
____

Patient/Guardian Signature: ____ Date: ______________

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FINANCIAL POLICY, HIPAA, & PHYSICAL THERAPY CARE CONSENT FORM

Clinic Financial Policy

Insurance Plans Billed – None.

You, the patient, are responsible for paying out-of-pocket at the time of service. Our office will provide the patient with a Super Receipt/Invoice to submit to his/her insurance plan for reimbursement. Angela Grenier, PT, DPT does not accept payment from any insurance company except for personal injury claims (auto-accident and worker's comp).

Time of Service Fee Schedule

- New and follow-up patient visit 60 minutes - $120

Missed Appointments or Late Cancellations: ***72 hour notice is appreciated, cancellation <48 hours results in a $50 charge, and 24 hours or less cancellation results in a charge of the full visit missed.***

Personal Injury Claims & Billing

- Auto accident and worker's comp related injuries require verification of an existing claim prior to examination and treatment.
- If examination and treatment for auto and work-related injuries are not covered by any or all personal injury insurance companies involved, I, the patient, am responsible for all fees for treatment.
- Payment is due at the time of service.

HIPPA Notice of Privacy Practices

Your protected health information may be used and disclosed by your physician, our staff, and others outside of this office that are involved in your care for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. All your information is strictly confidential. Please direct your questions to our office.

Examination & Treatment Consent

Physical therapy examination and therapeutic procedures (including joint mobilizations and manipulations, heat/ice application, therapeutic exercise, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal manipulation is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications such as stroke are estimated to be in the range of .5 – 2 incidents per million manipulations of the neck, and 1 per million for manipulations of the low back.

I have read and understand the above statements regarding treatment side-effects. I was made aware of procedures, alternative treatments, risks, and I was provided the opportunity to ask questions regarding recommended treatment(s) &/or procedure(s). I also understand that there is no guarantee or warranty for a specific cure or result.

Please read the following carefully:

- I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, pacemaker, etc.), I should discuss this with the physician because it may affect care.
- Notice to pregnant women: all females must alert their doctor if suspecting or having confirmed pregnancy as some therapies prescribed could present a risk to the pregnancy.
- I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Journey to Health PT reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with payment and/or reasonable treatment plans.

______________________________ ______________________________ _____/_____/_______

Patient/Guardian PRINT NAME Signature Date

____ _____/_____/_______

Signature (Dr. Angela Grenier, PT, DPT, LMT or relief doctor) Date