



Kwan-Yin Healing Arts Center
2330 NW Flanders, Suite 101
Portland, OR 97210
(503) 701-8766

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, Body Workers, Psychologists, Medical Doctors, Physical Therapists and Chiropractic Physicians. 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.

We are located just west of the intersection of NW 23rd on NW Flanders (between 23rd & 24th Ave.). Parking is available in the main and lower lot; please do not park below the building in the covered area. Wheelchair access for the first floor is located through the main level parking lot. Please come a few minutes early and enjoy a cup of tea before your appointment.

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.

PATIENT NAME: _____ PATIENT DOB: _____

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 Chelesa Mayer and/or Claudia Hammerstein 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, counseling (including but not limited to visualization for improved lifestyle strategies), 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 cranio-sacral 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).

PATIENT NAME: _____ PATIENT DOB: _____

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, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury; 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
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Printed Name of Guardian	Signature of Guardian	Date
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PATIENT NAME: _____ PATIENT DOB: _____

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:

PATIENT NAME: _____ PATIENT DOB: _____

Pelvic Floor Therapy

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: _____
- ≥ 4 week of kegels Pessary/External Catheters Biofeedback

Symptoms: (check all that apply)

- Leaking with without activity Leaking with activity
- Leaking with coughing/sneezing/laughing Urinary frequency issues
- Urinary urgency issues Pressure/heaviness feeling in pelvic region
- Pressure at the end of the day Pressure with straining
- Pressure during Menstrual Cycle Bulging or Protrusion in the vaginal area
- Pelvic pain/tension Other: _____

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

How many times per day do you urinate? _____

How many times per night do you urinate? _____

If you experience leakage, how often do you experience leakage?

- Less than once a month A few times a month few times a week Every day and/or night

If you experience leakage, how much urine do you lose each episode?

- Drops Small splashes More

If you have a pain condition, please complete the following:

Pain Symptoms Description:

- Burning
- Dull Ache
- Sharp
- Sharp- with movement
- Throbbing
- Radiating
- Numbness/tingling
- Anus
- Testicles
- Other: _____ Describe: _____

Site:

- Hip
- Buttocks
- Tailbone
- Thigh
- Back
- Pelvis
- Vagina

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

PATIENT NAME: _____ PATIENT DOB: _____

Symptoms are worse with/Aggravating factors:

- Activity
- Bending
- Lying
- Reaching
- At rest
- Sitting
- Standing
- Transitions
- Cough/Sneeze
- Stress/Anxiety
- Menstrual Cycle
- Intercourse
- Other: _____

Symptoms are better with/Easing Factors:

- Activity
- Rest
- Positioning
- Lying Down
- Walking
- Heat
- Ice
- Medications
- Massage
- Avoiding Intercourse
- Menstrual Cycle
- No relief
- Other: _____

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:

Birth History: Only Answer the next 4 questions if you had a pregnancy and/given birth

How many pregnancy have you had? _____ How many births? ___ Vaginal ___ Cesarean

Did any of your child weigh 8 pounds or more? ___ Yes ___ No

Did you have any of the following? Severe tearing Episiotomy Forceps delivery Vacuum Delivery

Did you have urinary or bowel incontinence within the first few weeks after delivery? ___ Yes ___ No
___ Type

Menstruation: Answer the next 3 questions if you are still menstruating:

When was your last menstrual period? _____

Is there any possibility you could be pregnant? ___ Yes ___ No

Are you using any form of birth control? ___ Yes ___ No If yes, what type? _____

Answer the next 2 questions if you are no longer menstruating:

Are you going through or have you gone through menopause? ___ Yes ___ No

Are you currently using hormones? ___ Yes ___ No

Lifestyle/Diet Information:

What do you do for exercise? _____

Frequency/Duration: _____

PATIENT NAME: _____ PATIENT DOB: _____

Pelvic Floor Therapy

Do you leak with exercise? ___ Yes ___ No

Do you smoke cigarettes? ___ Yes ___ No If yes, how many packs per day? _____

Do you drink caffeinated beverages? ___ Yes ___ No If yes, how many cups per day? _____

Do you drink alcoholic beverages? ___ Yes ___ No If yes, how many drinks per week? _____

Are you sexually active? ___ Y ___ N What is your sexual orientation? _____

Have you ever been raped or forced to engage in any sexual activity against your will? ___ Y ___ N

Have you ever been hit, punched or otherwise hurt by someone? ___ Y ___ N

Do you feel unsafe in your currently relationship? ___ Y ___ N Or from a past relationship? ___ Y ___ N

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)

- Diabetes Heart Disease Stroke Arthritis Asthma
- Hypertension Heart Attack Thyroid Disease Pneumonia COPD
- High Cholesterol Irregular heartbeats Cancer- List type: Tuberculosis HIV/AIDS
- Glaucoma Seizures Dementia Emphysema Anxiety
- Intestinal Problems Blood clots Fibromyalgia 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: _____

Gynecological Medical History: (please check all that apply)

- Cystitis Endometriosis Prolapse Hemorrhoids Pelvic inflammation
- Fibroids/Cysts Sexually transmitted diseases
- Vulvadynia Rectal surgery Urinary tract infection
- Hysterectomy, Type: _____ Bladder, Type: _____
- Other: _____

Is there anything else you would like to share? _____

PATIENT NAME: _____ PATIENT DOB: _____