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, 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

KWAN-YIN HEALING ARTS CENTER 2330 NW FLANDERS ST. SUITE 101 PORTLAND, OR 97210
PH: 503.701.8766 FAX: 503.241.5484 WWW.KWANYINHEALINGARTS.COM

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):

□ Burning	□ Head/neck
□ Dull Ache	□ Mid-back
□ Sharp	□ Shoulder
□ Sharp with movement	□ Elbow/Wrist
□ Throbbing	□ Low Back
□ Radiating	□ Pelvis/Buttock Region
□ Numbness/tingling	□ Hip
□ Knee	
□ 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:	**Symptoms are better with/Easing Factors:**
□ Activity	□ Activity
□ Bending	□ Rest
□ Lying	□ Positioning
□ Reaching	□ Lying Down
□ At rest	□ Walking
□ Sitting	□ Heat
□ Standing	□ Ice
□ Transitions	□ Medications
□ Cough/Sneeze	□ Massage
□ Stress/Anxiety	□ No Relief
□ Other:______________________________	□ Other: _____________________________

PATIENT NAME:____ PATIENT DOB:____________________

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**?**____

Frequencey/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)

□ 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:____

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