Client Registration

Name:_____ Date:_____

DOB:_____ Email:_____

Full Address:_____

Phone: Home: _____ Cell:_____Occupation:_____

Emerg. contact and phone:_____ Relationship to pt._____

How did you hear about *ALIGN*?_____

ALIGN Integration | Movement does not participate with any insurance companies. Clients are required to pay at the time of service and will be given a receipt to submit to their insurance provider for reimbursement. ALIGN cannot be responsible should your insurance company decide not to reimburse you. Please understand your out-of-network medical coverage and prescription requirements.

Patient Signature_____ Date_____

www.alignforhealth.com susan@alignforhealth.com 801.859.4142

This is a very thorough questionnaire asking very important questions for our evaluation process. Please fill this out as completely as possible to provide me with a clear picture of your present symptoms, abilities and goals.

Medical History Disclosure Form

Name:_____

1. What is the primary complaint that brings you to ALIGN Integration | Movement?

a) When did your symptoms first appear? Have you had it before this occurrence?

b) Have you ever been treated for this/these problem(s) before? When, what, where, by who, for how long?

c) Did prior treatment successfully manage or resolve the problem at that time? please explain

d) How did your symptoms begin? ie. after an accident, injury, physical or emotional trauma, or without reason?

e) Is it the SAME, BETTER or WORSE since onset? Circle one

2. Secondary complaint? Please summarize above questions here:

3. What activities increase your pain/symptoms?

4. What activities ease your pain/symptoms?

5. **What are your functional goals for this treatment program?** What activities from above would you like to be able to perform/tolerate, and for how long? ex: Be able to walk for 3 miles without pain in order to maintain exercise program. ex: be able to sleep for 5 hours without waking up due to symptoms.

1.

2.

3.

6. Place a **check mark** in front of each item that you experience **at least monthly**. Place an **X** in front of anything you experience **more frequently** than that.

headache	cold hands/feet	blurred vision
teeth grinding	high personal stress	severe menstrual cramps
trembling	painful urination	stiff/sore joints
heart racing	coughing	earache, ringing
difficulty sleeping	anxiety	stomach cramps
skin rashes	urinary leakage	fibrotic breasts
irregular heartbeat	sinus congestion	allergies
fatigue	thoughts of suicide	acid reflux
water retention	irregular bowels	back problems
chest pain/tightness	hopelessness	nausea, vomiting
faint/dizzy	constipation	
urinary frequency	asthma	
numbness, tingling	feeling overwhelmed	
tense/nervous	unable to have sex	
incomplete urination	sore, aching muscles	

7. Please circle any/all illnesses you've either had in the past or currently have:

Cardiovascular disease	Asthma/Breathing difficulty	Heart disease
Depression	High Blood Pressure	Diabetes
Epilepsy/Seizures	Anemia	Osteoporosis
Multiple Sclerosis	Thyroid Condition	Migraines/headaches
Stroke or Heart Attack	Fibromyalgia	Kidney disease
Chronic infections	Arthritis	HIV/AIDS
Eating disorder	Drug or Alcohol Abuse	
Dizzy/Vertigo	Hepatitis/liver disease	
Neurological condition	Fibromyalgia	

Cancer (Type)_____; Location(s) _____; Year:_____

Please list surgeries: _____

_____

Do you have any implanted medical device? _____

Are you pregnant or is there a possibility that you are?_____

8. MEDICATIONS: Please indicate below ALL medications you are currently taking, the problem for which you are using them for, dosage, and effectiveness.

Medication	Treatment for	Dose/amt/day	Effectiveness

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE & TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES I WILL INFORM YOU IMMEDIATELY.

Signature & Date: _____

Pelvic Floor Therapy Questionnaire

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries_____

Birth weight of largest baby _____ Number of cesarean deliveries_____

Number of episiotomies _____ Date of last Pap smear_____

Did you have any trouble healing after delivery Y N

Do you have a history of sexual abuse or trauma Y N

Are you having regular periods/ menstrual cycles Y N

Do you have frequent urinary tract infections Y N

Pain

Do you have pain with:

Sexual intercourse Y N

Pelvic exam Y N

Tampon use Y N

Back, leg, groin, abdominal pain Y N

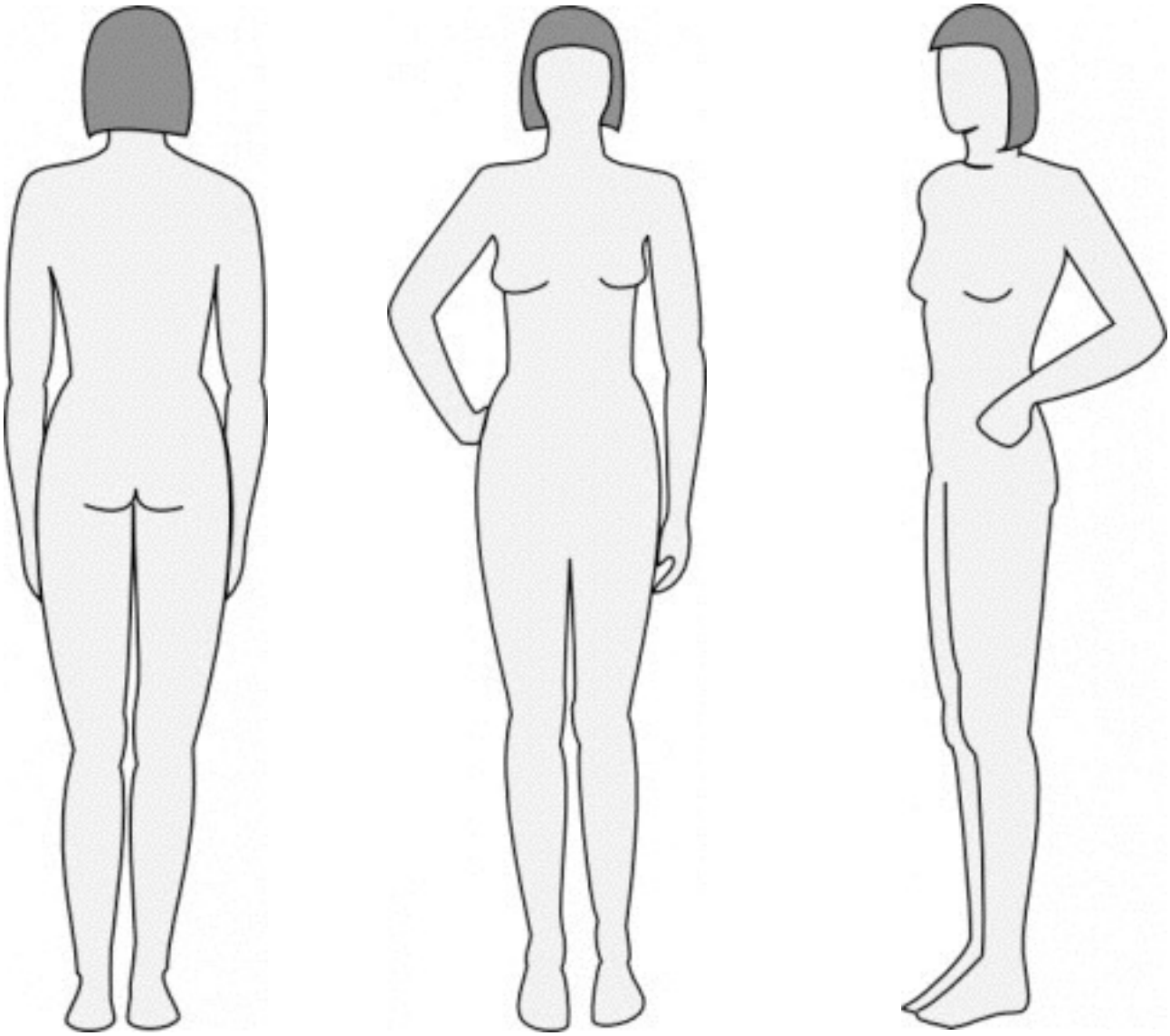
Tests

Urodynamics test Results:_____

Cystoscope Results:_____

Urine test Results:_____

Bowel test Results:_____



Please shade in areas of pain or symptoms. On side view, please indicate if your symptoms are on the left or right side. Rate shaded areas 1-10 based on severity (10 is worst pain).

www.alignforhealth.com susan@alignforhealth.com 801.859.4142

Bladder symptoms

Do you lose urine when you:

Cough/ sneeze/ laugh Y N

Lift/exercise/dance/jump Y N

On the way to the bathroom Y N

Have a strong urge to urinate Y N

Hear running water Y N

Do you wet the bed Y N

Have burning/ pain with urination Y N

Difficulty starting a stream of urine Y N

Strain to empty your bladder Y N

Feel unable to empty bladder fully Y N

Have a falling out feeling or pressure in your pelvis Y N

Have pain with a full bladder Y N

Have an urgency of urination(a strong urge to urinate) Y N

Urinate more than 7 times/day Y N

Bowel symptoms

Strain to have a bowel movement Y N

Leak / stain feces Y N

Include fiber in your diet Y N

Have diarrhea often Y N

Take laxatives / enema regularly Y N

Have pain with bowel movement Y N

Have a very strong urge to move your bowels Y N

How often do you move your bowels: _____ per day, week

Most common stool consistency:
____ liquid ___ soft ___ firm ___ pellets ___ other: _____

Thank you for taking the time to fill out this questionnaire.

Cancellation Policy

ALIGN Integration | Movement believes that each appointment you have scheduled is very important for your healing process. If you know that will need to cancel and reschedule your appointment, please allow 24 hour notice to allow us to reschedule another person who could potentially fill the time slot.

ALIGN has instated the following cancellation policy:

1. Please allow 24 hour notice with all cancellations.

2. Align charges $50 for all cancellations made within 24 hours prior to your scheduled appointment time. **This applies to all cancellations regardless of cause**.

3. You will receive an invoice for the cancellation fee of $50.

Please note that an appointment is only CHARGED as a cancellation if you do not give 24 hour notice.

I have READ and UNDERSTAND this cancellation policy for Align Integration & Movement, PLC. If I have any questions regarding this policy, I have clarified them with the staff.

Signature: _____ Date: _____

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal or rectal sensors for biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.

2. I understand that I can terminate the procedure at any time.

3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.

Date: _____ Patient Name: _____

_____ _____

Patient Signature Signature of Parent/Guardian (if applicable)