Client Registration

Name:_____ Date:_____

DOB:_____ Email:_____

Full Address:_____

Phone: Home _____ Cell:_____ Occupation_____

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

Referred by:_____

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_____

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. What activities increase your pain/symptoms?

3. What activities ease your pain/symptoms?

4. **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.

5. 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	

6. 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	Other:	

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

Surgeries _____

_____

Do you have any implanted medical device? _____

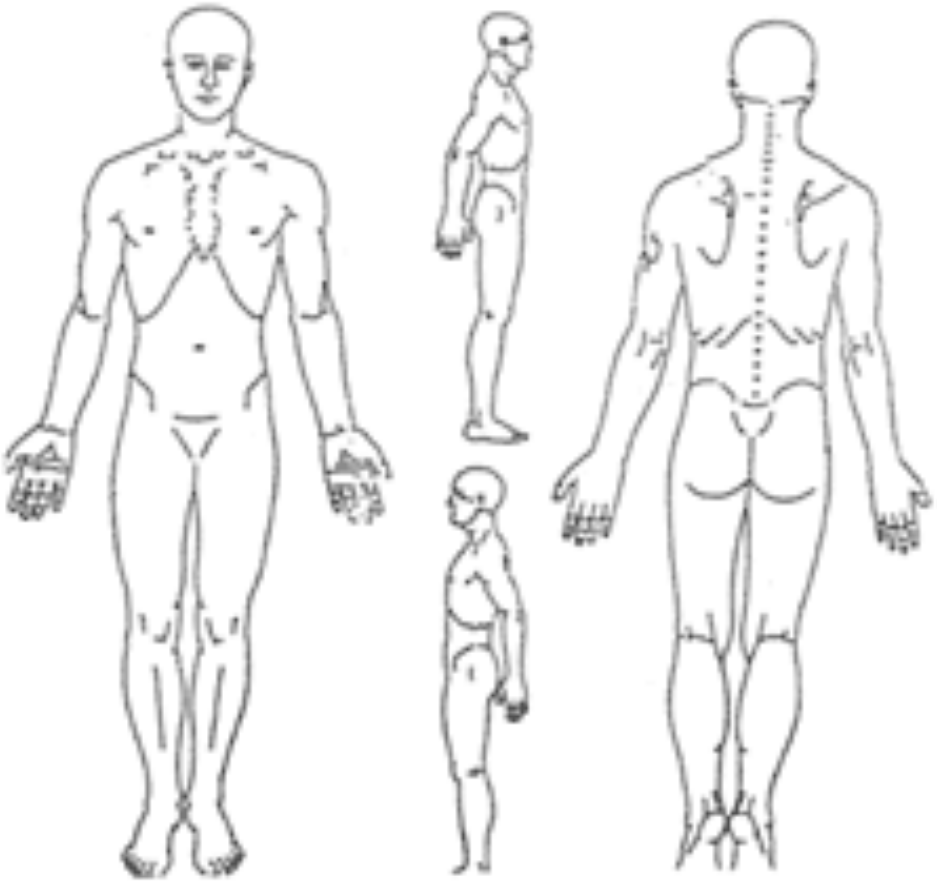
Are you pregnant or is there a possibility that you are?_____

13. 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: _____



Please shade in areas of pain or symptoms.

www.alignforhealth.com susan@alignforhealth.com 801.859.4142

Cancellation Policy

ALIGN integration | movement, PLC 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*. If I have any questions regarding this policy, I have clarified them with the staff.

Signature: _____ Date: _____

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At *A*LIGN integration | movement, we use a variety of procedures to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. I understand that I have the obligation to inform my therapist about any pain, discomfort or other negative sensation I experience in the course of therapy. I also understand I have the obligation to inform my therapist about any changes in my symptoms, medications, or any medical diagnosis I have received. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

Name_____ Signature_____ Date_____