Align
PHYSICAL THERAPY

24 Salt Pond Road, Suite D4~ Wakefield, RI 02879
Tel (401) 667 - 4965 ~ Fax (401) 667 - 7243
www.AlignPhysicalTherapyRI.com

Patient Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____

CellPhone: _____ **Text / VoiceMail? (please circle one or both)**

Home Phone: _____ **May we leave a message? Y / N**

e-mail: _____ **May we contact you via email? Y / N**

Referring Physician: _____ **Primary Care Physician:** _____

Profession: _____ **Emergency Contact Person:/Phone:** _____

How did you hear about us?: _____

CURRENT SYMPTOMS:

Chief Complaint / Symptom history: _____

_____

_____

Pain Intensity (Minimum to Maximum): 1 2 3 4 5 6 7 8 9 10

Medications: _____

Related Surgeries / Dates: _____

Other Medical Diagnoses: _____

MEDICAL HISTORY: (Check all that apply) If "YES", please explain by the side, or on the back

YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Cancer
☐	☐	Heart Disease	☐	☐	Osteoporosis
☐	☐	Stroke	☐	☐	Numbness / Tingling
☐	☐	Chest Pain	☐	☐	Dizziness / Vertigo
☐	☐	Pacemaker	☐	☐	Weakness in arms or legs
☐	☐	Diabetes	☐	☐	Shortness of Breath / Asthma
☐	☐	Fear of Falling	☐	☐	Difficulty Walking
☐	☐	Frequent Loss of Balance	☐	☐	Other (describe)

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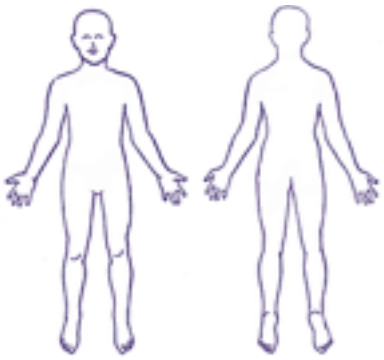
DIAGNOSTIC TESTS: (Check all that apply)

☐ X-rays ☐ CT Scan ☐ MRI ☐ Bone Scan

SYMPTOMS: (Please shade symptomatic areas)



PATIENT AUTHORIZATION:

- I authorize use of this form on all of my insurance submissions.
- I request that payment of authorized benefits be made on my behalf to Align Physical Therapy.
- I understand that my signature authorizes that payment be made and that my medical information be released in order to pay the medical claim.
- I understand that I am responsible for any deductible, co-payments, and non-covered services.
- I understand that I am responsible for any unpaid balance on my account.
- I permit a copy of this authorization to be used in place of the original.
- If you need to cancel an appointment, we ask that you notify us at least 24 hours in advance to avoid a $30 fee.
- I understand that frequent cancellations or missed appointments without notice may lead to dismissal from our practice
- I have received and reviewed a copy of the Patient Notice of Privacy Practices.
- I hereby authorize my consent to treatment.

If you are not the patient, please specify your relationship to the patient:

Patient's Signature: _____ **Date:** _____

_____ _____

_____ _____