SAUNDERS THERAPY CENTERS

SUBJECTIVE / MEDICAL HISTORY INFORMATION

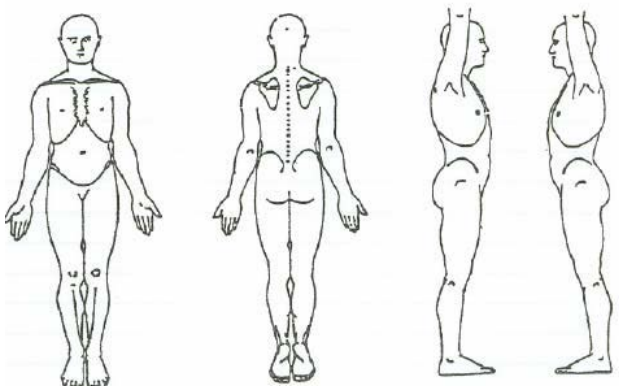
PATIENT INFORMATION							
Patient Name:		**Date of Birth:**		**Date:**			
Referring Physician:		**Age:**		**Height:**		**Weight:**	

1. Please indicate the date your symptoms began:
(Please indicate specific date if possible) _____/_____/_____

2. Surgery Date: _____/_____/_____
(Related to present problem, if applicable)

3. Using the key below, indicate on the body diagrams where your symptoms are located:

X=Pain O=Tingling //=Numbness



Circle below indicating your pain at its lowest and highest levels:

Lowest: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

Highest: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

4. Since onset are your symptoms getting: (check one)
◯ better ◯ worse ◯ not changing

5. What relieves (R) or aggravates (A) your symptoms?

☐ Sitting	☐ Rest	☐ Massage
☐ Heat	☐ Standing	☐ Medication
☐ Cold	☐ Walking	☐ Nothing
☐ Stretching	☐ Exercise	☐ Lying down
☐ Wearing a splint/brace		☐ Coughing/sneezing
☐ Other: _____		

6. As the day progresses do your symptoms: (check one)
❑ increase ❑ decrease ❑ stay the same

7. Does pain wake you at night? ❑ Yes ❑ No
If "yes" is it present:
❑ while lying still ❑ when changing positions ❑ both

8. Do you have pain/stiffness getting out of bed in the morning? ◯ Yes ◯ No

9. Since your symptoms began have you had:
❑ none
❑ fever / chills / nausea / vomiting
❑ any numbness in genital / anal area
❑ numbness / tingling / burning
❑ dizziness / fainting
❑ weakness
❑ unexplained weight change
❑ night sweats / pain
❑ problems with vision / hearing / speech
❑ any difficulty with bladder / bowel function
❑ headaches
❑ other _____

10. Treatments previously received for this condition:

none	☐ biofeedback
medication	TENS
Chiropractic	☐ injection / acupuncture
bracing/taping	☐ casting / immobilization
massage	hospitalization
	other _____

11. Please check / list any other health care providers you are currently seeing for this condition: ❑ None

❑ MD _____	❑ Dentist
❑ Podiatrist	❑ Chiropractor
❑ Physical Therapist	❑ Other _____

12. Please check if you had any of the following for this condition:

❑ None	❑ EMG	❑ X-rays
❑ CT scan / MRI	❑ Other _____	

GENERAL HEALTH

Dominant hand (circle): L R

How would you rate your overall health?
❑ Excellent ❑ Good ❑ Average ❑ Fair ❑ Poor

Are you pregnant? ❑ No ❑ Yes date due: __/__/__

Apart from your daily activities, do you exercise or perform vigorous activity?
❑ Not at all ❑ Seldom ❑ Occasionally ❑ Regularly

Do you drink caffeinated beverages?
❑ No ❑ Yes _____ / day

Do you smoke?
❑ No ❑ Yes _____ packs / day

What is your stress level?
❑ Low ❑ Medium ❑ High

MEDICATION

Please list any prescription and/or over the counter medications you are currently taking (pain pills, injections, skin patches, aspirin, vitamins, etc.)
❑ See attached list

_____ _____
_____ _____
_____ _____
_____ _____

PAST / CURRENT MEDICAL HISTORY

Have you ever had / been diagnosed with any of the following conditions? (check all that apply)
❑ None
❑ Cancer _____
❑ Heart problems
❑ Pacemaker
❑ Stroke
❑ Kidney problems
❑ Thyroid
❑ Epilepsy / seizures / dizziness
❑ Diabetes
❑ Arthritis–OA/RA, osteopenia/osteoporosis
❑ Head injury
❑ Circulation/vascular problems
❑ Infectious disease
❑ Spine problems / surgery
❑ Chemical Dependency
❑ High blood pressure
❑ Depression
❑ Lung problems/asthma
❑ Incontinence
❑ Blood disorder/anemia
❑ Multiple Sclerosis
❑ Allergies
❑ Latex allergies
❑ Fractures
❑ Stomach problems
❑ Parkinson's
❑ HIV
❑ Other _____
❑ List any other surgeries _____

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following?
❑ Diabetes ❑ Cancer
❑ Stroke ❑ Arthritis – OA/RA
❑ Heart disease ❑ Psychological condition
High blood pressure
❑ Other _____

LIVING SITUATION

What is your current living situation? (check all that apply)
❑ Live alone
❑ Live with family members/others/caregiver
❑ home/apartment/retirement complex(independent/assisted)

Mode of transportation: _____

Environment (barriers, obstacles):
❑ Stairs – railing ❑ No stairs
❑ Stairs – no railing ❑ Elevator
❑ Other _____

WORK HISTORY

Occupation: _____
❑ Full time ❑ Part time ❑ Unemployed
❑ Retired ❑ Student ❑ Self employed
❑ Other _____

Physical activities at work:
❑ Sitting ❑ Driving
❑ Standing ❑ Repetitive lifting
❑ Computer use ❑ Heavy lifting
❑ Phone use ❑ Heavy equipment operation

Current working status:
❑ Full duty
❑ Restricted duty ❑Work days missed: _____

If not performing your normal activities at work, do you plan to return to your previous activity level?
❑ Yes ❑ No

If this is a Work Comp claim – Do you have a QRC?
❑ Yes ❑ No

Are you seeking disability or are you consulting an attorney for this condition?
❑ Yes ❑ No

Patient / guardian signature:_____

M.D. follow up: ____/____/____

Reviewed by therapist:_____
Date:____/____/_____

SAUNDERS THERAPY CENTERS

New Patient Information Form

PATIENT INFORMATION	
Patient Name:	**Date:**

*** Fill in circles completely ***

Mark all that apply

1. For which body part(s) or for which problem(s) are you seeking Physical Therapy?

- ☐ head
- ☐ face / jaw
- ☐ neck
- ☐ shoulder
- ☐ elbow
- ☐ arm
- ☐ hand/wrist
- ☐ chest
- ☐ mid / upper back
- ☐ low back
- ☐ pelvis
- ☐ hip
- ☐ leg
- ☐ knee
- ☐ ankle
- ☐ foot / toes
- ☐ incontinence
- ☐ balance / walking
- ☐ dizziness
- ☐ other

2. Describe your symptoms / problems:

- ☐ pain
- ☐ weakness
- ☐ numbness/tingling
- ☐ stiffness / movement
- ☐ other
- ☐ constant
- ☐ intermittent
- ☐ sharp
- ☐ dull
- ☐ burning
- ☐ mild
- ☐ moderate
- ☐ intense / severe
- ☐ post surgical

3. Which of the following describes how your problem started?

- ☐ overuse / repetition
- ☐ gradually
- ☐ incident at work
- ☐ motor vehicle accident
- ☐ recreation or sport
- ☐ incident at home
- ☐ a fall
- ☐ other

4. Current limitations:

- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ up and down steps
- ☐ in / out of vehicle
- ☐ lifting
- ☐ kneeling / squatting
- ☐ reaching up
- ☐ reaching behind back
- ☐ gripping / pinching
- ☐ turning head
- ☐ looking up
- ☐ looking down
- ☐ sports / recreation
- ☐ none
- ☐ yawning
- ☐ chewing
- ☐ talking
- ☐ other

We Care About Your Privacy

To Our Patients

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose health information.

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to therapists, doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized, or at another provider's office.

For Payment. We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may remove information that identities you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Use and Disclosure of Your Health Information in Certain Special Circumstances

The following special circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To Federal officials for intelligence and national security activities authorized by law.

7. To correctional Institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your Rights Regarding Your Health Information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to the clinic manager.

4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the clinic manager.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact the clinic manager.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the clinic manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Acknowledgement:

Please acknowledge your receipt of this Notice of Privacy Practices by providing your signature below:

Signature: _____
(Under 18, parent or guardian must sign)

Date: _____

SAUNDERS
THERAPY CENTERS

Cancellation and No-Show Policy

Thank you for choosing Saunders Therapy Centers. We encourage regular attendance in accordance with your plan of care you have established with your Physical Therapist. This will maximize your successful outcome.

In an effort to accommodate all of our patients, we must enforce a cancellation and no-show policy. The appointments you make represent time set aside specifically for you.

- **ALL CANCELLATIONS SHOULD BE MADE AT LEAST 24 HOURS PRIOR TO THE SCHEDULED VISIT EXECPT IN THE CASE OF ILLNESS OR EMERGENCY**
- **ALL NO-SHOW OR CANCELLATIONS WITHIN 24 HOURS WILL BE CHARGED A $35.00 FEE**
- **PATIENTS WHO CANCEL OR NO-SHOW ON THREE SEPARATE OCCASIONS WITHOUT GOOD CAUSE WILL NOT BE ALLOWED TO RESCHEDULE UNTIL THEY HAVE SPOKEN WITH THEIR THERAPIST.**
- **ALL FUTURE APPOINTMENTS SCHEDULED WILL BE TAKEN OFF THE SCHEDULE AFTER 2 CONSECUTIVE NO SHOWS.**

Thank you for your consideration of our therapist's time and other patient's ability to schedule appointments.

I understand the terms of this form. I realize that I am financially responsible for the charges incurred from cancellations or no- shows.

Patient/Guardian Signature: _____ **Date:** _____