WELCOME TO SAUNDERS THERAPY CENTERS

Please share how you heard about us: _____

PATIENT INFORMATION

Legal Name Last, First, Middle Initial

Date of Birth	**Email Address**

Mailing Address

City, State, Zip

Legal Sex (please check one) ☐ **Female** ☐ **Male** *While Saunders Therapy Centers recognizes a number of genders/sexes many insurance companies and legal entities unfortunately do not. Please be aware that the name & sex you have listed on your insurance must be used on documents pertaining to insurance, billing, & correspondence. If your preferred name and pronouns are different from these, please let us know.*	Preferred Name: Pronouns:

Referring Physician	**Clinic Name & City**	**Clinic Phone**

PATIENT PHONE NUMBERS

Please provide at least one contact phone below:	**Type (check one)**	**May we leave detailed voicemails?**
Phone:	☐ **Cell** ☐ **Home** ☐ **Work**	☐ **Yes** ☐ **No**
Phone:	☐ **Cell** ☐ **Home** ☐ **Work**	☐ **Yes** ☐ **No**

INSURANCE INFORMATION

Primary Insurance Company Name	**Are you the primary insured on this plan?** ____Yes____No If No, please provide that person's information below:
Member#	**First, Last Name**
Group # (OR Work Comp Claim#)	**Date of Birth**
	Relationship
Secondary Insurance Company Name	**Are you the primary insured on this plan?** ____Yes____No If No, please provide that person's information below:
Member#	**First, Last Name**
Group#	**Date of Birth**
	Relationship

WORKERS COMPENSATION AND MOTOR VEHICLE PATIENTS ONLY

Date of Injury:	**Employer Name:**
Area of the Body Injured:	
Social Security#:	**Employed** ☐ **Full time** ☐ **Part time** ☐ **Retired** ☐ **Other**

IN CASE OF EMERGENCY

Name	**Contact #**	☐ **Cell Phone** ☐ **Home** ☐ **Work**

APPOINTMENT REMINDERS

Which contact number above should we use for your appointment reminders? ☐ Cell ☐ Home ☐ Work

Please indicate if you would prefer appointment reminders by: ☐ Phone Call or ☐ Text Message

NO-SHOW & LATE CANCELLATION POLICY

It is important that you understand our appointment cancellation and no-show policy. We encourage regular attendance in accordance with your plan of care you have established with your Physical Therapist. This will maximize your successful outcome.

You will receive an automated reminder 48 hours prior to your scheduled appointments. 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 must be made no later than 24 hours prior to the scheduled visit
- **All no-show or late cancellations (less than 24 hours notice) will be charged a $35 fee.**
- All future appointments scheduled will be taken off the schedule after two consecutive no-shows or chronic cancellations.

Thank you for your consideration of our therapist's time and assisting us in ensuring we are able to make appointments available to other patients on waiting lists if you are unable to attend.

CONSENT TO TREATMENT & ASSIGNMENT OF INSURANCE BENEFITS

I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures.

I authorize the release of information obtained during evaluation or treatment required for payment purposes to my insurance company. I assign Saunders Therapy Centers the medical benefits to which I or my dependents are entitled under my health insurance. I understand that I am financially responsible for all charges including charges not covered by my insurance, and for any reasonable collection fees required to collect delinquent accounts.

I agree to receive information about my care by email or text. I have been given access to the notice of privacy practices.

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

Patient/Guardian Name:_____

PATIENT INFORMATION

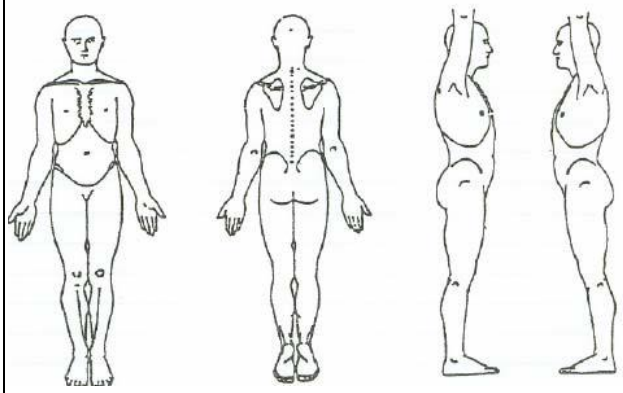
Referring Physician:		Age:		Height:		Weight:	

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

2. Are your symptoms related to any of the following (check all that apply):
❑ Motor Vehicle Accident ❑Sports Injury ❑Work Accident

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

4. 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 ☹

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

6. 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: _____		

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

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

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

10. 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 _____

11. Treatments previously received for this condition:

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

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

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

13. 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:_____

SAUNDERS
THERAPY CENTERS

NOTICE OF PRIVACY PRACTICES

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Patient Address: _____

Patient Email: _____

Patient Phone Number: _____

INFORMATION TO BE RELEASED TO/FROM (circle one) **SAUNDERS THERAPY CENTERS:**

☐ 6550 York Avenue South, Suite 520 Edina MN 55435
Phone: 952-924-0199 Fax: 952-924-0314

☐ 2334 University Avenue, Suite 170 St. Paul, MN 55114
Phone: 651-645-8083 Fax: 651-645-8078

☐ 10900 73rd Avenue North, Suite 110 Maple Grove, MN 55369
Phone: 763-315-1296 Fax:763-315-1297

INFORMATION TO BE RELEASED FROM/TO (circle one)**:**

Name: _____

Address: _____

Email: _____

Phone Number: _____

Relationship to patient (Clinic, Attorney, Family, etc): _____

INFORMATION TO BE RELEASED (check all that apply)**:**

☐ All Medical records on file.

☐ Specific treatment dates: from: _____ to: _____

☐ Other (please provide specifics) _____

METHOD OF INFORMATION RELEASE (check all that apply)**:**

☐ Mail to the address checked above.

☐ Fax to the number checked above.

☐ Verbally discuss with a therapist located at the address checked above.

Unless specified otherwise below, this authorization will remain in effect for 1 year from the date of signature.

☐This request expires on _____(date)

PATIENT PRINT NAME:_____

PATIENT SIGNATURE:_____

Date:_____

PELVIC DYSFUNCTION QUESTIONAIRE

Do you now have or have you had a history of the following? Explain 'yes' responses & include dates.

Y/N Abdominal pain
Y/N Joint problems
Y/N Allergies
Y/N Low back /sciatica
Y/N Bladder cancer
Y/N Pelvic pain
Y/N Bladder infections
Y/N Pelvic trauma
Y/N Blood in urine
Y/N Sensitivity to latex
Y/N Broken bones
Y/N Sexual/ physical abuse
Y/N Other (please list)_____

Y/N Childhood bladder problems
Y/N Sexually transmitted disease
Y/N Constant dribbling of urine
Y/N TMJ
Y/N Constipation
Y/N Trouble emptying bladder
Y/N Fecal incontinence
Y/N Trouble feeling bladder fullness
Y/N Fibromyalgia
Y/N Trouble holding back gas
Y/N Irritable Bowel Syndrome
Y/N Trouble initiating urine stream

Explain "yes" responses:_____
_____
_____
_____

Surgical History:

Y/N Surgery for your back/spine
Y/N Surgery for bladder
Y/N Surgery for brain

Y/N Surgery for abdominal organs
Y/N Surgery for female organs (if applicable)
Y/N Surgery for your prostate (if applicable)

Other type please describe:_____

OG/GYN History: (If Applicable) Explain 'yes' responses and include dates.

Y/N Painful periods
Y/N Fibroids
Y/N Painful penetration
Y/N D&C procedure
Y/N Pregnancies #_____
Y/N Endometriosis
Y/N Vaginal deliveries #_____
Y/N Cysts
Y/N C-section # _____
Y/N Vaginal Dryness

Y/N Episiotomy/ Tears # _____
Y/N Pelvic inflammatory disease
Y/N Difficult childbirth
Y/N Unusual discharge
Y/N Uterine/rectal/bladder prolapsed
Y/N Perimenopause
Y/N Prolapse or falling out feeling
Y/N Menopause (date of last period)

Explain "yes" responses:_____
_____
_____
_____
_____

Diagnosis specific to current problem not already indicated:_____
_____

Medications: **Start Date:** **Reason for taking:**
_____
_____

Bladder Habits

1. Are you unable to stop the flow of urine when on the toilet? **Y/N**
2. Is it difficult to tell when you need to go to the toilet? **Y/N**
3. Do you strain to pass urine? **Y/N**
4. Do you empty your bladder before you experience the urge to urinate? **Y/N**
5. Do you have difficulty completely emptying your bladder? **Y/N**
6. Do you have difficulty initiating the stream of urine? **Y/N**
7. Do you have triggers that make you feel you cannot wait to use the toilet? **Y/N**
8. Do you have pain or burning with urination? **Y/N**
9. Do you have pain or discomfort when you wipe yourself? **Y/N**
10. Do you leak more during, before or after your period? **Y/N**

Bowel Habits

1. Are you unable to feel that you need to have a bowel movement or pass gas? **Y/N**
2. Do you strain to have a bowel movement? **Y/N**
3. Do you feel your rectum is not completely empty after a bowel movement? **Y/N**
4. Do you have difficulty initiating a bowel movement? **Y/N**
5. Do you have pain or burning with bowel movements? **Y/N**
6. Do you have a history of hemorrhoids **Y/N**
7. Have you experienced a change in you bowel habits? **Y/N**
   If 'yes' please describe: _____
8. Do you take anything to help you pass stool? **Y/N**
   If 'yes' please list: _____
9. Do you have difficulty holding back gas? **Y/N**

Pelvic Floor Symptoms

1. Are you sexually active? **Y/N**
2. Do you have pain with intercourse or penetration? **Y/N**
3. Do you have pain with use of tampons? **Y/N**

SAUNDERS
THERAPY CENTERS

BLADDER AND BOWEL SYMPTOM QUESTIONNAIRE

1. **How often do you urinate during the day?** _____times, at night? _____ times.
2. **How often do you have a bowel movement**? _____times/ day/ week?
3. **How often do you experience bowel /bladder leakage?** (please circle all that apply)
   Never less than daily daily throughout the day nighttime/sleep
4. **What is the amount of leakage?** (please circle all that apply)
   No leakage soils pad or underwear soils outerwear
   How many do you use per day? _____
5. **What type of protection do you wear?** (please circle all that apply)
   None pantiliner maxi pad specialty product other
6. **What causes you to leak?** (please circle all that apply)
   Vigorous activity (running, aerobics)
   Light activity (walking, light house work)
   Cough/ sneeze
   Walking to the toilet
   Strong urge to go
   Intercourse or sexual activity
   Other _____
7. **How long can you delay the need to urinate?** (please circle all that apply)
   Not at all 1-5 min 5-10 min 10-30 min 30+min
8. **How much fluid do you drink each day** (one glass = 8 oz or one cup)
   _____ Total glasses of liquid per day
   _____ # of caffeinated glasses per day
   _____ # of alcoholic beverages per day
9. **Rate your feelings as to severity of this problem from 0- 10, 10 being the worst.**
   0_____10

Additional Comments: _____

_____

_____

SAUNDERS
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CONSENT FOR EVALUATION AND TREATMENT

I understand that my physician has referred me to physical therapy for evaluation and treatment of pelvic floor dysfunction, and it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the rectum and/or vagina if applicable.

I understand that if I am uncomfortable with the assessment or treatment procedures at any time, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

I understand that I may refuse any part of the treatment plan that I am uncomfortable with.

I understand that at any time I may request to have another person present during the evaluation and treatment.

I hereby request and consent to the evaluation and treatment to be provided by the physical therapist.

Patient Signature: _____

Patient Name (please print): _____

Signature of Parent or Guardian (if applicable): _____

******If you are pregnant, have infections of any kind, have vaginal dryness, are less that 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to pelvic floor assessment.***