Welcome to Ocean Physical Therapy

OUR MISSION is to provide the highest level of patient care focused on your needs and executing a plan suited to meet your goals.

At OPT, we are functional movement specialists using a variety of treatment techniques and patient education to offer the very best care. We proudly provide extensive scheduled time for you with our licensed staff whose dedicated one-on-one attention will help you attain your goals. We commend you for taking the time to take care of your health!

EVALUATION/TREATMENT: Today, your Physical Therapist will evaluate your condition, establish and implement an individualized treatment program focused on your immediate needs/concerns. We recommend you follow up within 1-2 days to expedite treatment and complete education on your initial home exercise program. We recommend you schedule out 3x/week initially or per the MD prescription. As you improve, we will reduce the frequency accordingly. We will regularly progress your program and reassess your condition at the 6th visit and at 30 days to assure we are making progress toward your goals or to make modifications as needed.

CANCELLATIONS OR NO-SHOWS: Friendly reminder that we reserve extensive treatment times for your care. Consistency is vital to attaining your rehabilitative goals. When cancelling, please be advised that appointments cancelled within 24 hours of their scheduled time will incur a **fee of $60**, as we will not be able to fill those appointment times reserved for you without adequate advance notice.
INITIAL: _____

COVID Precautions: We offer private treatment rooms, gloves and cleaning supplies to keep your health our #1 priority. We ask that you help socially distance from others. Feel free to pre and post clean your own areas in addition to what our staff sanitizes prior to and after your visit.

FEES AND INSURANCE BILLING: ***As a courtesy, we have called to verify your physical therapy insurance coverage. This is only an estimate given to us by the insurance company. All copayments, coinsurance and deductibles are due when services are rendered. Once we receive an Explanation of Benefits from your insurance carrier necessary adjustments to your copays, coinsurance or deductibles will be made.***
Your insurance was verified on: _____ by Rep: _____ Ref #: _____ Staff initials: _____
PATIENT INITIAL: _____

HIPAA NOTICE OF PRIVACY PRACTICES: This notice describes how medical information about you may be used and disclosed. Please provide names and contact information of anyone you wish to include. Copies provided upon request. Please initial indicating it is okay to send e-mails or leave voice mails on your home/cell phone regarding your case/appts. **YES**: _____ **NO**: _____

_____ _____ _____
Signature of Patient or Responsible Party Printed Name Date

OCEAN PHYSICAL THERAPY Inc.
spine & sports rehab., Pilates & fitness training

Personal Information

Today's Date: ____/____/____ **Who can we thank for referring you?** _____

Is your condition accident related? Yes/ No Motor Vehicle Accident____ Work related accident _____ Other____

Patient Name: _____ **Date of Birth:** ___/___/___ **SS#**_____

Sex: Female / Male **Marital Status:** Single / Married / Divorced / Widowed / Separated

Address: _____ **Apt/Unit #**_____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____ **Home Phone:** _____ **Cell Phone:** _____

Emergency Contact Name: _____

Phone: _____ **Relationship:** _____

Employer Name: _____ **Job Title:** _____

Employer Address: _____ **Phone:** _____

Full Time / Part Time / Disabled / Retired / Other: _____

Student: Full Time / Part Time **School:** _____

Parent/Guardian/Primary Insurance Holder Employer Name: _____

Job Title: _____ **Employer Address:** _____

Phone: _____ Full Time / Part Time / Disabled / Retired / Other: _____

Appointment Reminder

Text ☐

E-Mail ☐

None ☐

Provider: ☐ AT&T

☐ Verizon

☐ T- Mobile

☐ Other:_____

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Current Medical Complaint

Date of injury/onset of symptoms: ____/____/____

Is your condition accident related? Yes/ No Motor Vehicle Accident_____ Work related accident _____

Other ____

Describe how injury/condition occurred: _____

_____

Handedness: Right / Left **Do you smoke?** Yes / No

My job/sport/school requires me to: walk / sit / stand / run / lift / carry / push / pull

Has your doctor restricted you from any activity? Lifting _____ lbs. Bending _____ Other _____

Management of injury to date: Physical Therapy / Chiropractic / Acupuncture / Ice / Heat / Other / None

Please list medications used relating to this injury: _____

Have you had: Injections / X-rays / CAT scans / MRI's for this problem? **YES** **NO**

Date(s): _____ **Body part:** _____

Describe pain: Constant / Intermittent / Occasional / Shooting / Burning / Aching / Sharp / Dull

Left / Right (area of body) _____

I have: Numbness in my_____ Tingling in my _____
Weakness in my _____ Headaches occurring _____

These specific activities **INCREASE** my pain:

_____

These specific activities **DECREASE** my pain:

_____

GOALS:

What goals would you like to meet by the end of physical therapy?

_____

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Medical History

Describe previous injuries or surgeries you have had:

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

Please write 'YES' or 'NO' as appropriate and <u>give details only if not addressed above:</u>

YES/NO		**DETAILS**
_____	Do you have a metal implant or pacemaker in your body?	_____
_____	Are you pregnant?	_____
_____	Do you have any loss/transplant/impairment of any organ?	_____
_____	Have you been diagnosed with cancer in any area?	_____
_____	Have you had weight loss not associated with a nutritional change?	_____
_____	Is your general health status poor?	_____
_____	Are you severely depressed?	_____
_____	Do you drink alcohol?	_____
_____	Balance problems / falls	_____

<u>Do you have irregularities of the following systems?</u>

_____	Head, ears, nose or throat	_____
_____	Lungs (asthma, cough, etc.)	_____
_____	Heart (high blood pressure, heart attacks, etc.)	_____
_____	Circulation (blood clots, poor circulation, etc.)	_____
_____	Gastro-intestinal (ulcers, etc.)	_____
_____	Eyes (including recent change in acuity)	_____
_____	Genitourinary (kidney, incontinence, etc.)	_____
_____	Musculoskeletal (fractures, sprains, arthritis, etc.)	_____
_____	Neuromuscular (weakness, strains, numbness etc.)	_____
_____	Neurological (stroke, Parkinson's, seizures, etc.)	_____
_____	Metabolic/endocrine (thyroid, diabetes, etc.)	_____
_____	Skin (rashes, etc.)	_____
_____	Dental (TMJ, etc.)	_____

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Name: _____ Date: _____

CURRENT MEDICATIONS FOR THIS CONDITION – PAIN/INFLAMMATION/MUSCLE SPASMS:

START DATE	DRUG NAME	DOSE	FREQUENCY

CURRENT MEDICATIONS NOT RELATED TO THIS CONDITION:

START DATE	DRUG NAME	DOSE	FREQUENCY

Falls:

Have you experienced a fall in the past year with injury? Yes No

Have you had 2 or more falls in the past year without injury? Yes No

If yes, patient screened positive for future fall risk requires a falls Plan of Care (POC)

Have you been in hospice anytime in the past year? Yes No

Is there a documented medical reason for not completing a risk assessment for falls?

(ie: wheelchair bound, non-weightbearing, immobile, etc.) Yes No

Additional options that are thoroughly researched and optimize health:

In combination with your physical therapy care are you interested in helping:

- Your immune health with fruit, veggie and berry supplementation? Yes No
- Your mental and physical well-being with essential oils Yes No
- Pain and inflammation:

  Modalities: Deep Tissue Laser, Massage, Electric Stimulation – TENS, Interferential Yes No

  Topically: Doterra, Deep Blue, BioFreeze, Frankincense Yes No

Height in inches: _____ Weight in pounds: _____

BMI: (for office use only)

(703 x weight (lbs) / height (ins)

BMI = _____

Patients Signature: _____ Todays Date: _____