OCEAN PHYSICAL THERAPY Inc.

spine & sports rehab., Pilates & fitness training

WH

MEDICAL HISTORY

Describe previous injuries or surgeries you have had:

____ **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	__________

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

Do you have irregularities of the following systems?

YES/NO		DETAILS
_____	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.)	__________

OB/GYN HISTORY

_____	Number of pregnancies	__________
_____	Number of vaginal deliveries	__________
_____	Number of cesarean deliveries	__________
_____	Number of episiotomies	__________
_____	Birth weight of largest baby	__________
_____	(Y/N) Any trouble healing after delivery?	__________
_____	Date of last pap smear	__________

Do you have a history of sexual abuse or trauma? Y N

Are you having regular periods/ menstrual cycles? Y N

Do you have frequent urinary tract infections? Y N

CURRENT COMPLAINTS

Pain symptoms (Please check all that apply):

Do you have pain with:

_____ Sexual intercourse
_____ Pelvic exam
_____ Tampon use
_____ Urination
_____ Having a bowel movement
_____ Back, leg, groin, abdominal pain
_____ Other ____________________

Location of pain: ____

Nature of pain: constant/intermittent/occasional burning/aching/shooting/sharp/dull

Bladder symptoms (Please check all that apply):

Do you lose control of urine when you:

_____ Cough/ sneeze/ laugh
_____ Lift/ exercise/ dance/ jump
_____ On the way to the bathroom
_____ Hear running water
_____ Other ____________________

Do you:

_____ Wet the bed
_____ Have difficulty starting a stream of urine
_____ Strain to empty your bladder
_____ Feel unable to empty bladder fully
_____ Have a falling out feeling
_____ Have pain with a full bladder
_____ Have a strong urge to urinate
_____ Urinate more than 7 times/day
_____ Other ____________________

Bowel symptoms (Please check all that apply):

Do you:

_____ Strain to have a bowel movement
_____ Leak / stain feces
_____ Include fiber in your diet
_____ Have diarrhea often
_____ Take laxatives / enema regularly
_____ Leak gas by accident
_____ Have pain with bowel movement
_____ Have a very strong urge to move your bowels

How often do you move your bowels: ______ per day/week

Most common stool consistency

____ liquid ___ soft ___ firm ___ pellets ___ other____

ACTIVITIES/WORK

I am currently on: Full-Time ______ Part-Time ______ Disability ______ Other __________________

Has your doctor restricted you from any activity: Lifting _____ lbs. Bending ______ Other ______________________

Previous to this injury my NORMAL job/activity status was *(circle as many as apply):*

Part-time / Full-time WORKER at ___________________________Company with job title of ___________________

Part-time / Full-time HOMEMAKER and/or RETIRED

Primary / Secondary CARETAKER of children ages ____

Part-time / Full-time _________ grade STUDENT at _______________ School majoring in__________________

I have to commute __________ minutes each way ___________ times a week.

PATIENT GOALS

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

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 heath:

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: ______________

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

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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____

Name of attorney/claims adjuster involved:____

Patient Name: ____ **Date of Birth:** ___/___/___

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

Address: ____ **Apt/Unit #**__________

City: ____________________________________ **State:** ________________ **Zip Code:** _______________

Email: ________________________ **Home Phone:** __________________ **Cell Phone:** ________________

Appointment Reminders – Circle One E-mail or Text

If text reminder, who is your cell phone carrier: ____

Employer Name: ___________________________________ **Job Title:** _____________________________

Employer Address: ____ **Phone:** ________________

Emergency Contact Name: ____

Phone: _________________________________ **Relationship:** ____________________________________

Primary Insurance Holder Employer Name: ____
(Mandatory – cannot bill without it)

If student, and insured under school insurance, school name: ____________________________________