OCEAN PHYSICAL THERAPY Inc.

spine & sports rehab., Pilates & fitness training

Welcome to Ocean Physical Therapy! Your doctor has referred you to physical therapy to identify and maximize your quality of life and movement. At OPT, we use a variety of treatment techniques and patient education to offer the very best care. We are proud to allow extensive scheduled time for you to be treated by a licensed physical therapist whose dedicated one-on-one attention will help you attain your goals.

Our mission is to provide the highest level of patient care. We hope that your experience here will be rewarding, both physically and educationally, so if there is anything our staff can assist you with, please let your physical therapist or front office staff know. Below is a list of what to expect in the coming weeks. ***We commend you for taking the time to take care of your health!***

TREATMENT: Today, your physical therapist will interview you, evaluate your condition, and establish an individualized treatment program for you. The results of the evaluation will be faxed to your referring physician. We may request that you come early to your future appointments in order to warm up with exercises you have already learned. Your physical therapist will prescribe a home exercise program to be carried out on your own which will be progressed during the course of your rehabilitation. This will significantly help you progress to your normal activity and is your responsibility.

OUR MULTIDISCIPLINARY APPROACH: We believe in taking an integrative approach to wellness. We include services to supplement the progress you are making with physical therapy, which can be incorporated during or at the completion of your rehabilitation.

- *Acupuncture*
- *Massage therapy*
- *Manual Fascial Stretch Therapy™*
- *Fitness training*
- *Pilates*
- *Monthly gym membership*
- *Percussive Massage*
- *Balance classes*
- *Prenatal fitness classes*

FINTNESS TRAINING: After your fifth visit, please schedule a Health and Conditioning session with one of our Trainers to review your progress, plan and other health goals.

CANCELLATIONS OR NO-SHOWS: Consistency is vital to attaining your rehabilitative goals. We encourage you to fulfill your prescription in its entirety. 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.

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. Rarely is insurance coverage at 100% so please be advised that it is your responsibility to monitor your coverage. All copayments, coinsurance and deductibles are due when services are rendered unless prior arrangements have been made.

HIPAA NOTICE OF PRIVACY PRACTICES: This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. *By signing this page below, you are acknowledging that you have read a copy of this notice.*

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

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Patient Information

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

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

Parent/Guardian/Primary Insurance Holder Employer Name:_____

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

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

School:_____

_____

Appointment Reminder

_____

Text ☐

E-Mail ☐

None ☐

Provider: ☐ AT&T

☐ Verizon

☐ T- Mobile

☐ Other:_____

Case Information

Date of injury or onset of symptoms:____/__/__ WC / Auto Accident /Surgery____/_____/_____Date

Describe how this accident occurred:_____

_____

Height: _____ **Weight:** _____ **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?

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?

_____

_____

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	_____

Do you have irregularities of the following systems?

_____	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.)	_____