OCEANSIDE
PHYSICAL THERAPY
SPECIALIZING IN PELVIC FLOOR, OBSTETRICS + ORTHOPEDICS

Patient Information:

Name:_____

Address:_____

Phone Number(s):_____

Email:_____

Date of Birth:_____

Describe any symptoms/concerns that bring you to physical therapy today:

What do you wish to get out of your physical therapy sessions:

Are there additional providers that you are working with currently who you wish for us to communicate with:

118 Portsmouth Avenue, Suite B101, Stratham, NH 03885
▪Phone: (603) 580-4494 ▪Fax: (603) 580-4495
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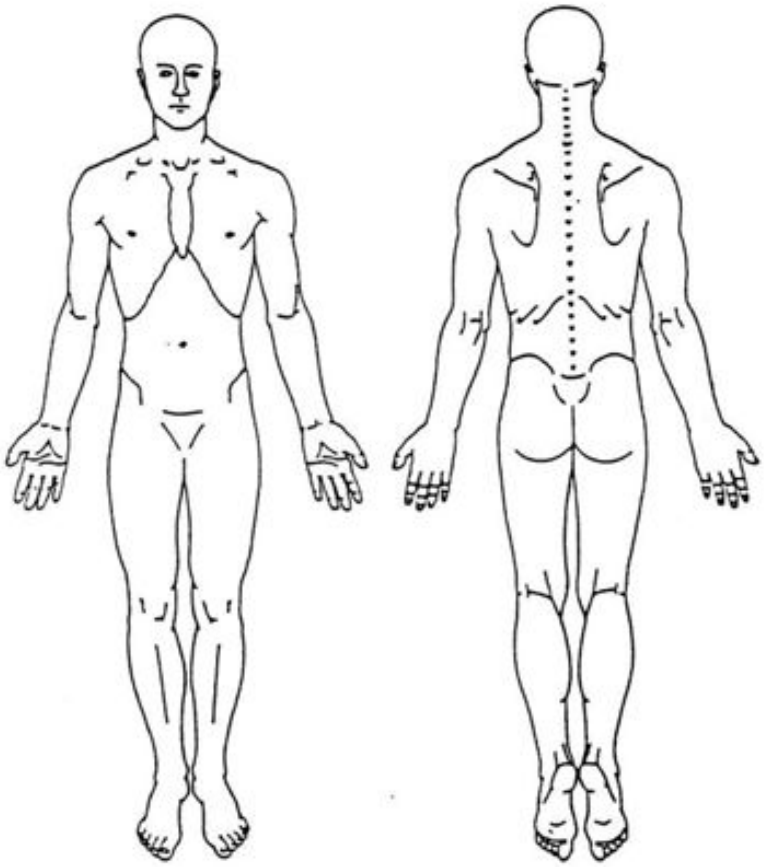
On the body diagram below, please describe your symptoms.



Symptoms: Please provide information on all that apply to you:

I feel that I have dysfunction with:		
• Sexual Function	• Standing	• In my back, leg, groin, hips
• Bladder	• Wearing Tight Clothes	• Medical Exams
• Bowel	• Exercise	• Other:
• Sitting	• At work	•

Please report any other symptoms that you feel are connected:

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Medical History: Please list *all* current medical conditions that you have or are being treated by other providers:

1.	5.
2.	6.
3.	7.
4.	8.

Surgical History: Please list *all* past surgeries and the date of the surgery:

1.	4.
2.	5.
3.	6.

Medications: Please list or attach a list of all your current medications, dosages, and how often you take them. Please include any vitamins or herbal supplements you are taking as well:

1.	5.
2.	6.
3.	7.
4.	8.

Overview of Systems: Have you experienced any of the following: (Circle any that apply.)

ALLERGIES:	
REPRODUCTIVE:	PCOS, Endometriosis, Irregular Cycles, Other Dysfunction:
ENDOCRINE:	Thyroid dysfunction, energy deficits, challenges with weight gain/loss
ENT:	Ringing in ears, Decreased Hearing, Ear pain or drainage Runny nose, Congestion, Sneezing, Sore throat, swallowing difficulty
CARDIOVASCULAR:	Chest pain (resting or with exertion), Palpitations (Heart beats fast or funny), Swelling, Swollen ankles, Leg pain when walking, Fainting or Blacking out, High Blood Pressure
RESPIRATORY:	Cough (day or night), SOB (rest or with exertion), sputum, and history of asthma / wheezing, bronchitis, pneumonia

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MUSCULOSKELETAL:	Pain or swelling in muscles or joints, weakness Arthritis, Osteoporosis, Bone fracture / joint injury, Gout
HEM/LYMPH:	Easy Bleeding or bruising, Lumps or bumps in neck, armpits, groin, breasts or testicles.
NEUROLOGICAL:	Numbness and Tingling, Fainting, Blackouts, Abnormal Jerking, Repetitive movements, history of seizures, tremors, tics
PSYCHIATRIC:	Anxiety, depression, moodiness, paranoia, or phobias Diagnoses:
SLEEP	Average hours/night: Do you have difficulty with sleep: YES NO
SKIN:	Acne, Dry, Flaky, Peeling, Rash, Redness, Itching, Recent change in moles/lesions/or birthmarks. Describe color / location / size:

When was your most recent yearly check up:_____

Special Diagnostics Test: Please check all that apply:

• EMG	• Pudendal Nerve Test
• MRI	• Anal Ultrasound- Manometry
• Cystoscope	• Defecation Proctogram Study
• Bladder Stress Test	• Urodynamic Testing
• Colonoscopy	• Food Allergy or Sensitivity Testing
• Urethral Dilations	• Other:

Bladder Symptoms: Please provide information on all that apply to you:

Yes	No	
		Do you lose urine when you:
•	•	Cough/sneeze/laugh
•	•	On the way to the bathroom
•	•	Hear running water
•	•	Lift/exercise/jump
•	•	Have a strong urge to urinate
•	•	During intercourse or sexual activity

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•	•	Other:
•	•	Do you have a slow, hesitant urine stream?
•	•	Can you stop the flow of urine?
•	•	Have pain or burning with urination?
•	•	Have difficulty starting a stream of urine?
•	•	Strain to empty your bladder?
•	•	Feel unable to empty your bladder fully?
•	•	Do you ignore the urge to urinate?
•	•	Have pain with a full bladder?
•	•	Have an urgency of urination (a strong urge to urinate)?
•	•	Find it necessary to wear a pad because of leaking? # per day:

How many times per day do you urinate? (circle one) 3-5 6-9 10-13 >13

How many times do you urinate after going to bed? (circle one) 0 1-2 2-3 >3

Bowel Symptoms: Please provide information on all that apply to you:

Yes	No	**Do You. . .**
•	•	Strain to have a bowel movement?
•	•	Include fiber in your diet?
•	•	Take laxatives/enema regularly?
•	•	Have pain with bowel movement?
•	•	Have a very strong urge to move your bowels?
•	•	Leak or stain feces (# times per day: week:)
•	•	Have diarrhea often?
•	•	Leak gas by accident?
•	•	Ignore the urge to defecate?
•	•	Have trouble getting to the toilet on time?

How often do you move your bowels: _____ Per day/week

What brings you to the bathroom? Do you feel an urge? Describe:_____

_____

Most common stool consistency:

_____Liquid _____Soft _____Firm _____Pellets _____Other:_____

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Please tell us how many pregnancies you have had, how many deliveries, and whether or not you had any complications:

Insurance Information:

Insurance Carrier:_____

ID #:_____

Subscriber's Name & Date of Birth:_____

Referring Physician:	**Primary Care Physician:**
Name:_____	Name:_____
Practice Name:_____	Practice Name:_____
Phone:_____	Phone:_____

Due to privacy regulations, we require your permission to leave messages (such as appointment reminders) on your answering machine or with any individual who answers the number you provide, identifying ourselves as "Oceanside Physical Therapy". Do we have permission to leave such messages? _____ Yes _____No Initials:_____
Do we have permission to send non-encrypted emails regarding scheduling or treatment to the email address provided? ____Yes____No Initials:____
Do we have permission to send you our practice newsletter via email to inform you of events and exercises classes being offered at Oceanside? ____Yes _____No Initials:_____

Patient Name (Please Print):_____

Patient Signature:_____

Signature of parent or guardian (if applicable):_____

Date:_____

HIPAA Patient Consent Form

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I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name:_____Date:_____

Signature:_____

Relationship to patient:_____

Release to additional parties:_____

_____

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Oceanside PT Cancellation Policy

Please provide our office with 24-hour notice when changing or cancelling an appointment. Please understand we are working in a healthcare system that values time over quality. We have taken a stand against this model and value quality, but never at the expense of time. We need time to listen and help you navigate this confusing healthcare system. We allot a significant amount of time for one-on-one sessions with highly skilled therapists. Therefore, we have a $50 cancellation fee for all visits. Payment for the first evaluation ($150) is taken at the time of scheduling and will be processed if the appointment is cancelled within 24 hours of the session or is not attended.

We realize that emergencies and sickness arise and are sometimes unavoidable; however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level.

Appointment reminders are set up at your first appointment and are sent out 48 hours prior to your appointment. Please listen to the time and date given or carefully read the reminder email. If the information is not what you are expecting or if you cannot attend, please contact us promptly so we can adjust the schedule accordingly.

Thank you for understanding this policy as it allows us to continue in our mission to provide care that is highly specialized, individualized and outside the norm of many physical therapy clinics.

Signature_____

Date:_____

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