Blue Lagune Therapy, Inc

Comprehensive Aquatic & Physical Therapy

Welcome to Blue Lagune Therapy, Inc.

Blue Lagune Therapy would like to thank you for entrusting your Physical Therapy needs in our care. There are many choices of therapy facilities to choose from, and because you chose Blue Lagune Therapy we commit to providing you with the highest level of quality care to assist you in a speedy recovery.

As part of your orientation, the following information will help guide you through your course of treatment. Please take a moment to review the following information so that you will know what you can expect from us. We kindly ask that you bring your own personal towel, and wear comfortable attire during your aquatic and/or land therapy session to allow your therapist access to the area being treated.

Your first visit will consist of a complete Physical Therapy evaluation performed by a licensed Physical Therapist. During the evaluation, your physical therapist will review your physical history, current condition, and perform a complete physical examination. The physical examination will consist of specialized tests designed to assess your body mechanics as well as your strengths and weakness. This enables our team to develop an individualized program specifically designed to treat your diagnosis and particular functional limitations. During this time, you will have the opportunity to discuss your goals and plan of care with your physical therapist. Our therapy staff is always readily available to discuss any issues regarding your condition throughout your course of treatment. Your treatment at our facility will be as positive and effective as possible. Our goal is to alleviate your pain and return you to your maximum level of function.

When your plan of care begins, please be advised of the following:

1. Physical therapy is very effective in treating many conditions and restoring normal function. Your therapist will develop a plan of care that will help you achieve your goals. Your responsibility is to work with your therapist and let them know how you are responding to treatment. During your first few treatments, you can occasionally expect normal soreness; however, your soreness should subside after a few days. If you experience increased pain or discomfort, it is important for you to relay this information to your therapist so that they may adjust your treatment or exercise program accordingly.

2. Every treatment visit counts towards your road to recovery! It is a very important part of your plan of care. Therapy requires your commitment, active participation, and dedication. Please be compliant to your scheduled appointments. Cancelled/no show appointments should be rescheduled for another time in the same day or during that week. We cannot adequately address your needs if you do not attend your therapy treatment on a regular basis. Maximum benefits are reached when you are consistently attending your therapy treatment. Progression is diminished when you attend sporadically. We kindly ask for you to make every effort to be on time to allow courtesy to other patient's treatment time.

3. A home exercise program (HEP) will be given to you following your first few treatments of therapy. It is essential that you are compliant with your HEP. We encourage you to communicate your progress with your therapist during each treatment, so that they will know if there is a need to adjust your treatment or update your HEP.

4. When you are closer to the end of your therapy referral/prescription, usually after 31 days from your initial evaluation, a re-evaluation will be performed by your physical therapist. Re-evaluation is performed to give you an update of your progress and to determine If therapy should be continued or not. We will inform your doctor of your progress. Your physician will review the re-evaluation to determine if continued therapy is medically necessary. We will obtain a new referral for the continuation of your therapy treatment if your physician recommends additional therapy.

We understand your time is valuable and attending your therapy session is time consuming and expensive; however, it is the least expensive and non-invasive form of medical treatments. In an effort to restore you to function quickly and

effectively, it requires attending therapy on a regular basis. As recommended and advised by your doctor, aquatic and/or physical therapy is the best course of action to assist you in regaining yourself to your maximum potential.

We value each session with you! Our physical therapy team will work diligently to help guide you through the exercises, strategies, and techniques to assist you in achieving your goals as outline in your plan of care.

Once again, we thank you for selecting Blue Lagune Therapy, Inc. to provide your therapy needs!

Best Wishes,

Blue Lagune Therapy, Inc.
1115 Avenue D
Katy, TX 77493

Blue Lagune Therapy, Inc

Comprehensive Aquatic & Physical Therapy

PATIENT INFORMATION

Patient Name: _____ Sex: M / F Marital Status: M / S / W / D

Date of Birth: _____-_____-_____ Social Security Number: _____-_____-_____

Driver's License #: _____ State: _____ Email: _____

Mailing Address:_____Home #: _____

City: _____State:_____Zip:_____Cell Phone #:_____

Patient Employer:_____Work #: _____

Occupation: _____ Spouse Name:_____ Spouse DOB:_____

Emergency Contact: _____ Phone #:_____

BILLING INFORMATION

Primary Insurance Co.:_____ Phone: (_____)_____-_____

Address:_____ City:_____ State:_____ Zip:_____

Primary Insured's Name: _____ SS# _____/____/_____ DOB_____/____/_____ Sex: M F

Insured ID#_____Group#_____ Relationship to the Patient __Self __Spouse ___Child___Other

Employer: _____ Phone: (_____)_____-_____

Secondary Insurance Co.:_____ Phone: (_____)_____-_____

Address:_____ City:_____ State:_____ Zip:_____

Secondary Insured's Name: _____ SS# _____/____/_____ DOB_____/____/_____ Sex: M F

Insured ID#_____Group#_____ Relationship to the Patient __Self __Spouse ___Child___Other

Employer: _____ Phone: (_____)_____-_____

Tertiary Insurance Co.:_____ Phone: (_____)_____-_____

Address:_____ City:_____ State:_____ Zip:_____

Tertiary Insured's Name: _____ SS# _____/____/_____ DOB_____/____/_____ Sex: M F

Insured ID#_____Group#_____ Relationship to the Patient __Self __Spouse ___Child___Other

Employer: _____ Phone: (_____)_____-_____

Have you had any chiropractic, physical, occupational/ speech therapy, or home health in the last 12 months? Yes / No

If yes, what treatment & when? _____

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

Motor Vehicle Accident

Is your injury due to a motor vehicle accident? Y / N If yes, when was the accident? _____

Auto Insurance Carrier Name_____Policy/Claim #:_____

Adjuster's Name:_____Adjuster Phone:_____Address:_____

Work Related Accident (Workers' Compensation)

Is your injury due to a work related? Y / N If yes, when was the accident? _____

Claim #_____

Workers' Compensation Insurance Carrier:_____ Phone:_____Fax:_____

Employer Name_____Are you still employed here? Y / N

Employer Address:_____ City:_____ State:____ Zip:_____

Adjuster's Name:_____ Phone:_____Fax:_____

Nurse Case Manager:_____ Phone:_____Fax:_____

Describe your injury:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Blue Lagune Therapy Inc Patient History

Name _____ Age: Ht: Wt: Date: _____

Occupation: _____ Are you currently on work restriction? _____

Are you currently receiving any Home Health Services? ☐ Yes ☐ No

Have you received any aquatic therapy, physical therapy, speech therapy, and/or chiropractic services? ☐ Yes ☐ No

Was this injury work related? ☐ Yes ☐ No
If yes, is this being filed under ☐ Workers Comp or ☐ Employer

Please list your diagnosis or involved area: _____
List the date of injury or approximate date of onset of your condition: _____

Have you had surgery due to your condition? ☐ Yes ☐ No
If yes, please list the date of surgery & type of surgery & description:

1)_____ 3)_____

2)_____ 4)_____

List all current medications & what they are used for:

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7) _____

4)_____ 8)_____

Do you have any allergies? Ie. Chlorine, latex etc….If yes, please lists them:

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6) _____

Are you diabetic? ☐ Yes ☐ No
If yes, are you taking oral medication or injections? ☐ oral ☐ injection

Have you abused alcohol or any illegal substances in the past 2 years? ☐ Yes ☐ No

Do you have any implants such as a pacemaker, pins, plates, screws, prosthetic joint, etc? ☐ Yes ☐ No

Please list any other information that may be a factor in your treatment (ie. Pregnancy, claustrophobia, fear of water, aversion to hot/cold etc.

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6) _____

Blue Lagune Therapy, Inc Patient History

PLEASE TELL US ABOUT YOUR CURRENT SYMPTOMS

1. How did your symptoms start? _____

2. Have you been hospitalized for this problem? ☐Yes ☐No When? How long? _____

3. What other treatment have you had for these symptoms? _____

4. My symptoms currently: ☐Come and go ☐Are constant ☐Are constant, but changes with activity

   ☐Getting Better ☐Getting Worst ☐Staying about the same

5. What tests have you had for these symptoms (MRI, X-rays)? _____

6. Does your symptoms changed by? ☐Sitting ☐Standing ☐Walking ☐Lying Other: _____

7. How are you able to sleep at night due to your current symptoms?

   ☐ I have no problem sleeping ☐ I have difficulty falling asleep

   ☐ I am awaken by pain ☐ I sleep only if I am medicated

8. How much of your daily activity are you able to do on a scale of 0 to 100%? _____

9. Where is most of your pain located (please circle)?

   Back Neck Shoulder Elbow Hand Hip Knee Ankle Foot

10. **Rate your pain** from **0-10** (0=no pain, 10=excruciating pain) for the following:

    Worst it has been: _____ Past 2-4 weeks: _____ Past 24 hours: _____ At this moment: _____