I look forward to seeing you at your first appointment. Sunshine Therapeutics is located at 277 Miami St, Waynesville, OH 45068 up the street from the Waynesville Post Office. Please note that treatments are done on the skin. You are welcome to wear your undergarments or a loose fitting pair of shorts and a tank top if you are not comfortable in your undergarments.

Please do not apply any lotion or oils to your body the day of the treatment as this will interfere with the myofascial release technique.

Please complete the attached paperwork and bring it with you to your session. I would greatly appreciate it if you could provide a doctor's script stating your medical diagnosis for needing occupational therapy and myofascial release. The doctor's script would read:

Occupational therapy for (example: back pain M54.5).

As an occupational therapist, I cannot diagnosis your ailment. If you have had any diagnostic testing such as an x-ray, MRIs, CAT scans, EKG, etc., please bring the write out of those reports to best guide me in your treatment.

Please note that I am not a provider for any insurance company, but will provide paperwork for you to submit to your insurance for reimbursement. I cannot guarantee reimbursement. If you would like to use a health savings account card, you must have a doctor's script. If you are a Medicare recipient, I am legally not able to see you for a medical purpose. I can see you under the classification that the sessions are for luxury purposes only. This means that you will not be provided a medical receipt for treatment. I do apologize for this, but it is Medicare's guidelines. I will do my best to guide you to another practitioner upon your request.

Please do not hesitate to contact me with any questions at 937-307-4174. I look forward to guiding you along your voyage to heal.

Godspeed and Many Rays of Sunshine to you,
Jocelyn Metzger OTR/L, Expert MFR therapist

INITIAL EVALUATION SUBJECTIVE REPORT

Please fill out the following form as accurately and as completely as possible to provide a clear picture of your present symptoms, abilities and goals. Please know the questions address your physical, mental, and emotional well-being. Thank you

Name_____ Date_____

Address_____

Home Phone_____ Other phone_____

Date of Birth_____ Email address_____

Referral Source_____

Referring Physician_____

Address_____

Phone/Fax_____

What is the **primary complaint** that brings you to the clinic? Please describe your symptoms as specifically as possible.

Secondary complaint?

On what **date did your symptoms begin?_____**

How did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

Put a slash mark on the line below to indicate the INTENSITY of your symptoms.

None_____Worst Possible

Put a slash mark on the line below to indicate the **FREQUENCY** of your symptoms.

Never_____Constant

What activities increase your pain?

What activities / interventions decrease your pain?

What previous interventions have you had for your condition(s)? For example: massage, physical therapy, occupational therapy, chiropractics, accupuncture, ect.

For each activity listed below, please mark you activity tolerance rating each one as either: **(P) Poor, (F) Fair, (G) Good, (N/A) not applicable**

Activity	Tolerance	Activity	Tolerance
Sitting		Computer work	
Standing		Exercise	
Walking		Writing	
Stairs (# of stairs/flights)		Shopping	
Driving		Bending	
Sleeping		Sports	
Lifting >10 lbs		Carrying >10lbs	
Other		Other	

What physical requirements are needed for you to complete your job?

Please circle your present level of stress: **none, a little, some, alot, overwhelmed**

When under stress, do you tend to: Fight Run Away Freeze
(If you do not know, please just start becoming aware of how you respond to stress)

Where do you feel discomfort in your body when you are under stress?
(If you do not know, please just start becoming aware of how you respond to stress)

What are your stressors/triggers for distress?

How do you presently manage your stress? What are your coping methods?

Would you describe your general current health as **Poor Fair Good?**

Please list any **known allergies** (i.e. food, chemical, latex, environmental):

MEDICAL HISTORY: Are you currently or have you ever experienced, been diagnosed with or received treatment for the following:

❑ Allergies	❑ Epilepsy
❑ Alcohol / drug dependence	❑ Fibromyalgia
❑ Anemia	❑ Headaches / Migranes
❑ Arthritis (osteo / rheumatoid)	❑ Heart disease
❑ Kidney or bladder problems	❑ Digestion problems
❑ Bleeding or bruising problems	❑ Hernia:
❑ Blood clots / phlebitis	❑ High blood pressure
❑ Cancer: radiation or chemotherapy	❑ Back problems:
❑ Broken Bones:	❑ Surgery:
❑ Parkinson disease	❑ Osteoporosis
❑ Sleep disturbances	❑ Pregnancy, if yes, how many: C-Section or Vaginal
❑ Chronic Fatigue syndrome	❑ Stroke
❑ Current fever	❑ TMJ
❑ Diabetes	❑ Thyroid disease or imbalance
❑ COPD	❑ Urinary Tract Infection
❑ Scoliosis	❑ Multiple Sclerosis
❑ Depression / Anxiety	❑ Other:

Past medical history (additional surgeries, accidents, traumas or other conditions and please include the year).

MEDICATIONS Please indicate below ALL medications which you are currently taking, the problem for which you are using them, the dosages.

Medication	For treatment of	Dose/amt/day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are your goals for this treatment program? For example, what activities would you like to be able to perform better or longer? What do you most miss being able to do comfortably?

CONSENT TO MEDICAL TREATMENT FROM SUNSHINE THERAPEUTICS, LLC.

Patient Name:
Date:

CONSENT TO TREATMENT: I hear by consent to the administration of hands on body work services as directed by Sunshine Therapeutics. This may include manual therapy, myofascial release, therapeutic exercise, kinesiotaping, neuromuscular reeducation, massage, and other modalities the practitioner feels are medically beneficial. I understand that the healing process varies for each individual and there are not guarantees or promises regarding the outcomes of this work.

I understand that the services are designed to be a health aid and are in no way to take the place of a doctor's care when indicated. I am aware that the therapist does not diagnose disease nor prescribe medications. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Information exchanged during any treatment session is educational in nature and is intended to help me become more aware and conscious of my own health status and is to be used at my own discretion. All information exchanged during a session will be kept confidential. I will inform my therapist of individuals in which I would like to be contacted regarding my treatments.
These individuals include:
1.

2.

3.

I authorize the release of medical records information to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary.

I have asked questions and received answers to my satisfaction to date knowing that as I progress with the work further questions may arise that will be answered to the best of the treating therapist's knowledge. If I experience any discomfort during the treatment, I will inform the therapist immediately. I have been instructed to wear clothing that I am comfortable wearing and that is appropriate for the treatment acknowledging that myofascial release is performed with direct touch to the skin.

I acknowledge that I have been informed of the nature, purpose, and risks of myofascial release treatments and other modalities and I am responsible for my own self-care. In order to facilitate my own self-healing I may be instructed in techniques that are specialized for me to complete at home. It is my responsibility to make sure I understand that in which I am instructed and listen to my body while completing these self-healing techniques.

CANCELLATION POLICY
Everyone gets one forgiveness for a cancellation less than 24 hours before a treatment or a no call, no show. After that, full payment is requested for the missed session.

FINANCIAL AGREEMENT: Payment is due at the time of services provided. I understand that I, the client am responsible for verifying insurance coverage, filing for authorization, submitting records for reimbursement if desired. Payment records and clinical records will be provided on request so that individuals may file for reimbursement if desired. Billing codes to submit to insurance for reimbursement will be provided. Please note that Sunshine Therapeutics will only provide wellness visits for non medically necessary reasons for clients with Medicare as it is unlawful for services to be provided for medical reasons on a cash pay basis for Medicare recipients. No receipt will be provided for Medicare recipients. I apologize for any inconvenience.

Name & Number of an Emergency contact: _____

Client Signature:_____**Date:**_____

For minors: I, as parent of_____, have read and agree with the above information giving consent for the treatment of my child.