Counterstrain San Diego

Full Name: _____
First M.I. Last

Birth Date: ____/____/____ Age: _____ Sex: M F

Address: _____
Street

_____
City State Zip Code

Home Number: _____ Cell Number: _____

Email: _____

How did you hear about Counterstrain San Diego? (please circle)

Family Friend Another Therapist The Jones Institute

Please provide the name of the person who referred you: _____

Emergency Contact

Full Name: _____
First M.I. Last

Home Number: _____Cell Number: _____

Current Health Information

Primary Complaint: _____

Pain Location: _____

Pain Quality: Constant Intermittent Dull/Achy Sharp/Stabbing Burning

Numb Tingling Spastic Cramping Sore

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No Pain Annoying Worrisome Bothersome Can't Move ER

My symptoms are: Mild Moderate Severe

My symptoms are getting: Better Worse Staying the Same

Prior Treatment: _____

Secondary Complaint: _____

Pain Location: _____

Pain Quality: Constant Intermittent Dull/Achy Sharp/Stabbing Burning

Numb Tingling Spastic Cramping Sore

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No Pain Annoying Worrisome Bothersome Can't Move ER

My symptoms are: Mild Moderate Severe

My symptoms are getting: Better Worse Staying The Same

Prior Treatment: _____

Additional Complaints: _____

Pain Location: _____

Pain Quality: Constant Intermittent Dull/Achy Sharp/Stabbing Burning

Numb Tingling Spastic Cramping Sore

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No Pain Annoying Worrisome Bothersome Can't Move ER

My symptoms are: Mild Moderate Severe

My symptoms are getting: Better Worse Staying The Same

Prior Treatment: _____

Daily Activities

Describe how your condition functionally limits you at:

Work: _____

Home: _____

Recreationally: _____

Do you exercise regularly: Y N Frequency: _____

What do you do for exercise: _____

Medical History

Please check all diagnoses/conditions that you experience:

- ☐ Headaches
- ☐ Sinus Issues
- ☐ Rashes/Skin Problems
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Degenerative Disorders
- ☐ Digestive Issues

- ☐ Concussions/Dizziness
- ☐ Depression
- ☐ Chronic Pain
- ☐ Heart Disease
- ☐ Blood Pressure Issues
- ☐ Respiratory Disease
- ☐ Cancer
- ☐ Diabetes

Please explain any checked boxes above: _____
_____
_____
_____

Please list all medications you are currently taking: _____
_____
_____
_____

Informed Consent and Patient Agreement

With the knowledge I acquired through the Counterstrain San Diego website and during my initial evaluation, I voluntarily consent to treatment, realizing that Counterstrain San Diego has given me no guarantees regarding cure or improvement of my condition. I hereby release Counterstrain San Diego from any and all liability which may occur in connection with treatment except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in treatment at any time. I understand that treatment requires clinicians to gently touch and manipulate aspects of my body. I understand that treatment is not a substitute for medical care and that it is recommended that I work with my Primary Care Physician I have. I ensure that I have, to the best of my ability, made Counterstrain San Diego aware of all my current medical conditions and medications. I understand that in extreme cases treatment may result in symptoms changing and soreness. I release my Physical Therapist of any liability if I fail to disclose the appropriate health related information.

I understand that a record of the health services provided to me will be kept. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that my Physical Therapist will answer any questions I have and that I may request of copy of the current Notice of Privacy Practices at any time.

I authorize Counterstrain San Diego to provide treatment to my child or dependent.

Patient Signature: _____ Date: _____

Name of Child or Dependent: _____

Parent or Guardian Signature: _____ Date: _____

Policies and Procedures

Treatment Rates:

The current rate for treatment is $150.00 /hr for Counterstrain sessions.

Cancellation Policy:

All services are provided by appointment only and this time is reserved for your exclusive time use. It is your responsibility to attend all scheduled appointments. Should you need to cancel an appointment, please do so 24 hrs before your scheduled appointment time. Failure to do so will result in a Cancellation Fee of half the full rate of the appointment. Not showing for an appointment without giving notice to Counterstrain San Diego will result in

a No Show Fee of the full rate of the scheduled appointment. Occurrence of multiple no shows may result in discharge from the facility.

The patient is ultimately responsible for all charges of labor rendered to you by Counterstrain San Diego. If you are covered under private insurance and would like, we can provide a receipt detailing treatment, charges, and payments that you can use in your own attempt to file a claim with your insurance company. We do not provide the service of submitting these claims for you. Payment in exchange for time and labor is due upon receipt of labor. Trades must be discussed prior to the rendering treatment.

By signing below, I confirm that these policies have been explained to me in terms which I understand.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____