TODAY'S DATE		OFFICE USE ONLY

Counterstrain Self Pay Form

PATIENT INFORMATION

FIRST NAME	LAST NAME	MI	NICKNAME	GENDER	DATE OF BIRTH	STUDENT: FT/ PT

HOME ADDRESS	CITY/ STATE	ZIP CODE

MARITAL STATUS	EMPLOYER NAME	RETIRED	SOCIAL SECURITY NUMBER

WORK ADDRESS	CITY/ STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE	MAY WE LEAVE MESSAGES?

EMAIL ADDRESS	WOULD YOU LIKE EMAIL REMINDERS OF APPOINTMENTS?

EMERGENCY CONTACT AND RELATIONSHIP	EMERGENCY CONTACT PHONE NUMBER

PRIMARY CARE PHYSICIAN	RETURN TO DOCTOR DATE	COMMENTS

REASON FOR TODAY'S VISIT

PLEASE DESCRIBE REASON FOR VISIT

OCCUPATION	DESCRIPTION

STATUS: full time, part time, light duty, retired, etc	DATES OFF WORK OR COMMENTS

Please continue on reverse side of form

Pain and Past Medical History

PAIN SCALE: 0=NONE; 5= MODERATE; 10 = EXTREME

AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

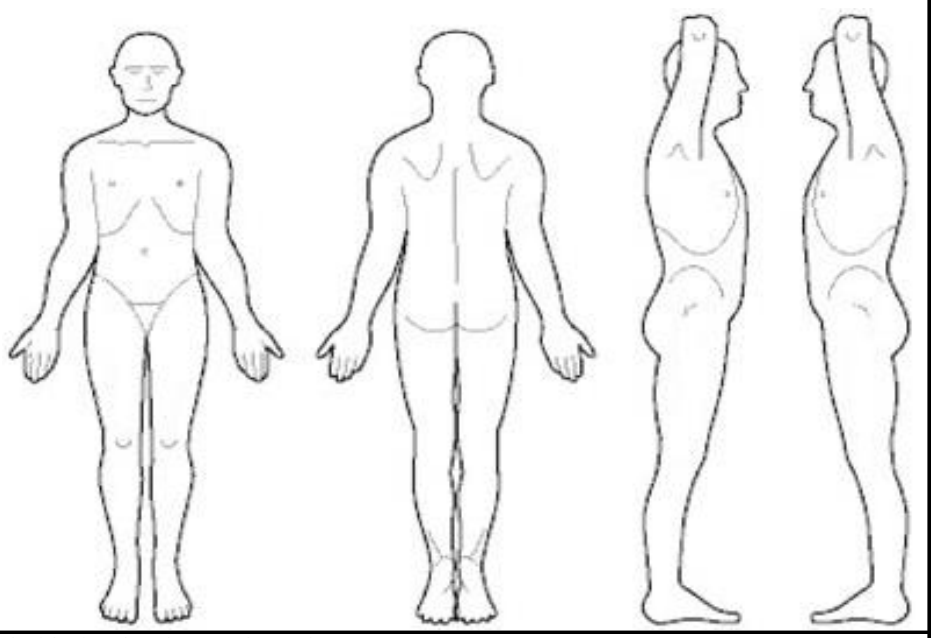
PAIN DESCRIPTION: burning, sharp, dull, achy, throbbing, shooting, numbness, tingling

PAIN LOCATION

Please draw in your symptoms on the diagram below.

PAIN with XXX NUMBNESS with OOO TINGLING with ///

R Front L L Back R R L



DIAGNOSTIC TESTING: X-RAYS, MRI CAT, etc.

MEDICAL HISTORY

Do you currently or have you in the past

had any of the following medical conditions?

- ☐ osteoarthritis
- ☐ Heart condition
- ☐ Diabetes
- ☐ allergies
- ☐ surgical history
- ☐ previous therapy
- ☐ fractures
- ☐ kidney disease
- ☐ osteoporosis
- ☐ fatigue
- ☐ stroke/TIA
- ☐ weight loss
- ☐ substance abuse
- ☐ bowel/bladder
- ☐ current pregnancy
- ☐ anxiety
- ☐ lung condition
- ☐ blood disorder
- ☐ cancer
- ☐ depression
- ☐ fever/ chills
- ☐ headaches
- ☐ cholesterol
- ☐ blood pressure
- ☐ infections
- ☐ psychological
- ☐ smoking history
- ☐ MS/ Parkinsons
- ☐ dizziness
- ☐ other

Have you ever hit your head? YES NO

Please explain all checked items

MEDICATION

NAME REASON

How did you hear about us?

Do you have anything artificial? (stents, joints, IUD, shunts)

Have you had therapy at Horizons in the past?