RR
ROB ROSENBERRY
Pain Management | Fascial Counterstrain

HEALTH HISTORY & NEW PATIENT INTAKE FORM

320 Alisal Road, Suite 406, Solvang, CA 93463 | t: (805) 688-5000 | e: info@robrosenberry.com | robrosenberry.com

Bold fields are required.

Date ______________________

Name (First, MI, Last) ______________________

DOB ______________________

Address ______________________

____

City, State, Zip Code ______________________

Home Phone ______________________

Work Phone ______________________

Mobile Phone ______________________

Emergency Contact Name ______________ **Phone** ______________

Relationship ______________________

Responsible Party Name ______________ DOB ______________

E-Mail ______________________

PCP or referring Physician ______________________

Address ______________________

____

City, State, Zip Code ______________________

Work Phone ______________________

Fax Phone ______________________

Medicare Patient? ☐ Yes ☐ No

How did you hear about us? ______________________

I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment.

Signature ______________________

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Current Health Information

Please list concerns and check all that apply

What is your Primary Complaint? ___________________

☐mild ☐ moderate ☐ severe
☐ constant ☐ intermittent
☐symptoms up w/activity ☐ symptoms down w/activity
☐ getting worse ☐ getting better ☐no change

Treatment received _____________________________
____
____

What is your Secondary Concern?_________________

☐mild ☐ moderate ☐ severe
☐ constant ☐ intermittent
☐symptoms up w/activity ☐ symptoms down w/activity
☐ getting worse ☐ getting better ☐no change

Treatment received _____________________________
____
____

Any Additional Complaints?_____________________

☐mild ☐ moderate ☐ severe
☐ constant ☐ intermittent
☐symptoms up w/activity ☐ symptoms down w/activity
☐ getting worse ☐ getting better ☐no change

Treatment received _____________________________
____
____

Have you ever received Manual Therapy before?

☐Yes ☐No Frequency?_______________________
____

If Yes, what are they?_____________________________
____

Daily Activities

Describe how your condition functionally limits the following activities.

Work____
____

Home/Family_______________________________________
____

Recreational_______________________________________
____

Check other activities affected:

☐ sleep ☐ washing ☐dressing ☐fitness

How do you reduce stress?____________________________
____

In general, do you prefer to sit or stand?__________________
____

If you are in acute pain, what is your most comfortable position?
____

Health History (continue on back)

Are you taking any medications? ________________________
____
____
____

List and explain. Include dates and treatment received.

Surgery____
____
____
____

Accidents____
____
____

Major Illnesses ______________________________________
____
____

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General

Current	Past		Comments
☐	☐	headaches	______
☐	☐	pain	______
☐	☐	sleep disturbance	______
☐	☐	fatigue	______
☐	☐	Fever	______
☐	☐	sinus	______
☐	☐	other	

Skin Conditions

Current	Past		Comments
☐	☐	rashes	______
☐	☐	athlete's foot	______
☐	☐	other	

Alergies

Current	Past		Comments
☐	☐	scents, oils, lotions	______
☐	☐	detergents	______
☐	☐	other	

Muscles and Joints

Current	Past		Comments
☐	☐	rheumatoid arthritis	______
☐	☐	osteoarthritis	______
☐	☐	osteoporosis	______
☐	☐	scoliosis	______
☐	☐	broken bones	______
☐	☐	spinal problems	______
☐	☐	disc problems	______
☐	☐	lupus	______
☐	☐	TMJ, jaw pain	______
☐	☐	spasms, cramps	______
☐	☐	sprains, strains	______
☐	☐	tendonitis, bursitis	______
☐	☐	stiff or painful joints	______
☐	☐	weak or sore muscles	______
☐	☐	neck, shoulder, arm pain	______
☐	☐	low back, hip, leg pain	______
☐	☐	other	

Nervous System

Current	Past		Comments
☐	☐	head injuries	______
☐	☐	concussions	______
☐	☐	dizziness	______
☐	☐	ringing in ears	______
☐	☐	loss of memory	______
☐	☐	confusion	______
☐	☐	numbness	______
☐	☐	tingling	______
☐	☐	sciatica	______
☐	☐	shooting pain	______
☐	☐	chronic pain	______
☐	☐	depression	______
☐	☐	other	______

Respiratory & Cardiovascular

Current	Past		Comments
☐	☐	heart disease	______
☐	☐	blood clots	______
☐	☐	stroke	______
☐	☐	lymphedema	______
☐	☐	high/low blood pressure	______
☐	☐	irregular heart beat	______
☐	☐	poor circulation	______
☐	☐	swollen ankles	______
☐	☐	varicose veins	______
☐	☐	chest pain	______
☐	☐	shortness of breath	______
☐	☐	asthma	______
☐	☐	COPD	______
☐	☐	other	

Cancer/Tumors

Current	Past		Comments
☐	☐	Benign	______
☐	☐	Malignant	

Digestive/Elimination system

Current	Past		Comments
☐	☐	bowel dysfunction	______
☐	☐	gas, bloating	______
☐	☐	bladder/kidney dysfunction	______
☐	☐	abdominal pain	______
☐	☐	other	

Endocrine System

Current	Past		Comments
☐	☐	thyroid dysfunction	______
☐	☐	diabetes	

Reproductive System

Current	Past		Comments
☐	☐	pregnancy	______
☐	☐	painful menses	______
☐	☐	fibrotic cysts	

Habits

Current	Past		Comments
☐	☐	tobacco	______
☐	☐	alcohol	______
☐	☐	drugs	______
☐	☐	coffee	______
☐	☐	ergogenic aides	

Movement & Exercise

Current	Past		Comments
☐	☐	Stretching/Yoga	______
☐	☐	Cardiorespiratory	______
☐	☐	Strength/Resistance	______
☐	☐	balance/speed/agility	______

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Contract for Care & Consent for Care

Contract for Care. I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my *manual therapist* and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my *manual therapist* any time I feel my well being is threatened or compromised. I expect my *manual therapist* to provide safe and effective treatment.
Consent for Care. It is my choice to receive *bodywork/manual therapy*, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my *manual therapist* of any changes in my health.

Signature/Date of parent or Signature/Date _______________

Signature/Date of parent or guardian if patient is a minor. _______________

INFORMED CONSENT and PATIENT AGREEMENT

I, the undersigned, hereby authorize ROB ROSENBERRY PHYSICAL THERAPY INC., to perform manual therapy and specific procedures necessary for Fascial Counterstrain (FCS) treatment.

What is Fascial Counterstrain (FCS)?

Fascial Counterstrain is a technique that uses gentle manual manipulations to help restore function to the fascial systems of the body (arterial, visceral, lymphatic, venous, dural, periosteal, and nervous systems). Benefits of FCS include stress reduction, circulation enhancement, increased relaxation, and relief from muscular tension, soreness, and pain.

Limitations of FCS:

FCS practitioners do not diagnose medical diseases or conditions and it is not a substitute for medical examination and treatment.

Self-care after treatment:

• Following a session, please make sure to consume at least 8-10 glasses of pure water.

• Try to avoid heavy lifting or heavy physical activity for the week following a session. If a simple position of comfort was enough to reduce pain, a simple painful effort is enough to restore it.

• If you receive handouts for home exercises, perform them at least once in the evening, every evening, or if you begin to feel any symptoms return.

NOTE: Please understand that despite the gentle nature of the fascial counterstrain technique, there is a very real possibility that you will get sore following a session. Sometimes in extreme cases you may feel worse. In most cases this is evidence of a powerful change in your body, not another injury. Usually, this is temporary and should not last more than 2-3 days. There is no way to predict how one will respond to fascial counterstrain treatment, but you can minimize the reaction by following the guidelines listed above.

Adverse Reactions to FCS:

Please provide complete details of medical conditions and medications to your treatment provider during the health-intake interview. Failure to inform the manual therapist of all medical conditions and medications may place you at increased risk for adverse reactions. If you experience any discomfort during the session, immediately inform your practitioner so he or she can adjust your treatment. Sometimes treatment is followed by temporary soreness, fatigue or discomfort related to tissue toxicity and the early stages of detoxification.

Informed Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that ROB ROSENBERRY PHYSICAL THERAPY INC. has given no guarantees to me regarding cure or improvement of my condition. I hereby release ROB ROSENBERRY PHYSICAL THERAPY INC. from any and all liability, which may occur in connection with the above-mentioned procedures 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 these procedures at any time. I understand that FCS requires practitioners to gently touch and manipulate my body. I understand that FCS is not a method to diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of FCS. I understand that FCS is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have and I have stated all my known physical conditions and medications. I also understand the benefits and limits of FCS therapy and understand it may cause adverse reactions in certain rare situations. I release my practitioner of any liability if I fail to disclose the appropriate health-related information.

I understand that a record will be kept of the health services provided to me. 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 practitioner will answer any questions I have.

I authorize the therapists of ROB ROSENBERRY PHYSICAL THERAPY INC. to provide treatment to my child or dependent.

Client's Signature: ____Date: _____________

Name of Child or Dependent: ____

Parent or Guardian Signature: __________________________________Date: ____________

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Solvang, CA 93463

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PAYMENT, BILLING AND CANCELLATION POLICIES

Business Rates and Billing: The current rate for manual therapy and bodywork is $225 per hour. Additional time, beyond the first hour of treatment, is not included in the initial charge. If additional time is used you will be charged an additional amount in proportion to the extra time.

For Clinic Director

- 1 hour 15 minutes = $280.00
- 1 hour 30 minutes = $335.00
- 1 hour 45 minutes = $390.00
- 2 hours = $445.00

ROB ROSENBERRY PHYSICAL THERAPY INC. accepts cash, checks and all major credit cards. We do not bill insurance companies for services. Plan to arrive 10 minutes early to complete your paperwork. Clients arriving late will be charged for the full session and the session will end promptly at the scheduled time. Clients must cancel sessions per the notice requirements stated below or pay for the missed appointment in full.

New Patients:
New Patients are required to provide credit card information to hold their initial appointment time. Your credit card will not be charged at time of booking and will not be charged in the case that a cancellation is made with appropriate notice given per the terms stated below.

Medicare Patients:
Due to the specialized nature of wellness services provided at ROB ROSENBERRY PHYSICAL THERAPY INC. our clinic does not accept Medicare. By signing this form, you are agreeing that you understand these policies and that you will not seek reimbursement through Medicare for any services provided or expenses incurred at ROB ROSENBERRY PHYSICAL THERAPY INC..

Cancellation Policy: All services are provided by appointment only and this time is reserved for your exclusive use. It is your responsibility to attend all scheduled appointments. Should you need to cancel an appointment, please refer to the below chart which details how far in advance appointments must be canceled in order to avoid incurring fees:

Length of Appointment	Required Notice for Cancellation
One Hour	24 Hours
Two Hours	2 Business Days
Three + Hours	3 Business Days

These requirements allow the time needed for your appointment to be given to someone else. Except in emergency situations, *not showing for an appointment without the correct amount of notice given will be charged the full rate of the scheduled appointment*. This fee is your responsibility.

NOTE: *Reminder calls are a courtesy service*; ultimately it is your responsibility to arrive for an appointment that you have scheduled. Not receiving a reminder call does not waive your responsibility to cancel or postpone an appointment at least 24 hours ahead of time. You will be charged for your appointment if this happens.

Extended Appointments: Reserving more than 12 hours per week will require a deposit for the first four hours to be paid when scheduling the appointment. Deposits will not be refunded if an extended appointment is canceled within 72 business hours before the first appointment. For example, an appointment that begins at 9:00am on a Monday would require notification by 9:00am on the Wednesday preceding the Monday appointment.

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NOTICE OF PATIENT INFORMATION AND PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN BELOW.

USES AND DISCLOSURES OF HEALTH INFORMATION
My “protected health information” means health information, including my demographic information, collected from me and created or received by ROB ROSENBERRY PHYSICAL THERAPY INC., another health care provider, a health plan, my employer, or a health care clearinghouse.

I consent to the use or disclosure of my protected health information by ROB ROSENBERRY PHYSICAL THERAPY INC. for the purpose of providing treatment to me, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care we provide. ROB ROSENBERRY PHYSICAL THERAPY INC. may use my information to contact me, provide appointment reminders, or correspond with my health care providers whom I have approved in writing, about my health car and treatment related information.

I understand that ROB ROSENBERRY PHYSICAL THERAPY INC. may use or disclose my personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. ROB ROSENBERRY PHYSICAL THERAPY INC. will also provide information when required by law. ROB ROSENBERRY PHYSICAL THERAPY INC. may change its policy at any time. When changes are made, a new “Notice of Privacy Practices” will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of the “Notice of Privacy Practice” at any time.

In any other situation, ROB ROSENBERRY PHYSICAL THERAPY INC. will obtain my written authorization before disclosing my personal health information. I have the right to revoke this consent, in writing, in any time to stop future disclosures of my information.

PATIENT RIGHTS
I have the right to review or obtain a copy of my personal health information at any time. I have the right to request a correction for any inaccurate or incomplete information in my records. I have the right to request a record of instances in which ROB ROSENBERRY PHYSICAL THERAPY INC. has disclosed my personal health information for reasons other than treatment, payment or other related administrative purposes.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the clinic. I also understand that ROB ROSENBERRY PHYSICAL THERAPY INC. considers such requests on a case by case basis, but the practice is not legally required to accept them. However, if ROB ROSENBERRY PHYSICAL THERAPY INC. agrees to a restriction that I request, the restriction is binding on ROB ROSENBERRY PHYSICAL THERAPY INC..

CONCERNS AND COMPLAINTS
If you are concerned that ROB ROSENBERRY PHYSICAL THERAPY INC. may have violated your rights or if you disagree with any decisions ROB ROSENBERRY PHYSICAL THERAPY INC. has made regarding access or disclosure of your personal health information, please contact the practice manager. You may also send a written complaint to the US Department of Health and Human Services.

By signing below I acknowledge that I have read and understand how ROB ROSENBERRY PHYSICAL THERAPY INC. will use my personal health information and what my rights are with regards to disclosure and restriction of my personal health information.

Patient Signature: ____ Date:________________________