Travel/Illness History Questionnaire

If any of your answers have an * next to it, PLEASE LET US KNOW IMMEDIATELY!

1. In the past 14 days, have you: ***YES NO**
   a. traveled internationally or flown domestically?
   b. traveled to any known COVID hot spots?
   c. had close contact with a college student who was sent home due to a COVID outbreak?

If you responded yes above, have you self-isolated or quarantined for 14 days? YES *NO

2. Have you had close contact with anyone (***family, close relationships, coworkers, etc.)*** who has travelled by air or to any of the COVID hot spots in the past 14 days? ***YES NO**

3. Have ***you OR a family member*** experienced any of the following symptoms or have ***you OR a family member*** been exposed to anyone who has had any these symptoms in the past 14 days?

   ****Fever, chills, generalized muscle aches/pains, cough, sore throat, shortness of breath, loss of smell or taste, new onset of unusual fatigue, headache that is unusual for you, diarrhea, nausea, abdominal pain, acute confusion, hives, redness in toes. *YES NO**

4. Have you or anyone in your household had any known exposure to the Corona Virus?

   ***YES NO**

5. Are your currently taking any medications to suppress a fever? ***YES NO**

6. Do you, or does anyone in your household work in a hospital, urgent care or primary care physician's office, daycare or in a setting, such as a restaurant or fitness center, where customers typically do not wear masks? ***YES NO**

7. Are you wearing a mask when out in the public or socializing indoors, practicing social distancing, avoiding gatherings of groups of 10 or more, and attempting to maintain 6 feet of distance between yourself and other people?

   YES *NO

I understand that it is my responsibility to immediately inform Progress Physical Therapy, LLC if I develop any of symptoms noted above, have had close contact with anyone else with these symptoms or diagnosed with Corona Virus, or if I have been advised to self-quarantine. I also understand that, if any of my answers have a * next to them, special accommodations may be made, my appointment *may* need to be re-scheduled or virtual visits will be offered, *if appropriate* to maintain the lowest possible risk of the spread of COVID at our office. I understand that Progress Physical Therapy, LLC has a strict policy that all who visit will wear a mask (no valve on mask) that covers their nose and mouth for the entire time visiting our office, even when social distanced from others. I will call 804-270-7754 and let Progress Physical Therapy, LLC know if I am unable to follow this policy before arriving at the clinic.**

Name (Print) ___________________________ Signature _____________________________ Date ______

Dba Progress Physical Therapy, LLC

Patient Name________________________ Subscriber ID #________________ Primary Language________

What is your occupation?____

Describe your current nutrition concerns____

____

____

Check if you have any difficulty with: ☐ Seeing ☐ Hearing ☐Swallowing ☐Speaking/Talking ☐ Memory

FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following:

☐ Diabetes
☐ Heart Disease
☐ Kidney Disease
☐ Chemical Dependency (i.e. Alcoholism)
☐ Ehlers-Danlos Syndrome
☐ Other
☐ Cancer
☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
☐ Stroke
☐ Depression
☐ Osteoporosis

MEDICAL HISTORY

Please check all of the following that apply to you:

□ Celiac Disease
□ Crohn's Disease
□ Diverticulosis
□ Rheumatoid Arthritis
□ Other Arthritic Conditions
□ Thyroid Disease
□ Type 1 Diabetes
□ Type 2 Diabetes
□ High Blood Pressure
□ High Cholesterol
□ Irritable bowel disease
□ Stroke/CVA (Date)_________
□ Blood Clots
□ Asthma
□ Emphysema/Bronchitis
□ PCOS
□ Multiple Sclerosis
□ Lupus
□ Depression
□ Alcohol/Drug Dependence
□ Stomach Ulcers
□ COPD
□ Hepatitis

□ Cancer If Yes, describe what kind & treatment _______________________________________

□ Heart Problems If Yes, describe what kind & treatment _______________________________________

□ Kidney Problems If Yes, describe what kind &treatment _______________________________________

Are you now, or have you ever been, a smoker? ☐ Yes ☐ No

If Yes, how many packs of cigarettes do you smoke a day? __________________

Have you ever taken an anticoagulant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Have you ever taken steroid medications for any reason? ☐ Yes ☐ No

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Are you currently pregnant or think you might be pregnant? Estimated Delivery Date? ___________ ☐ Yes ☐No

CURRENT MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc.). You may attach a copy of your own list of medications if available. Only fill out the post-surgery medications if this section applies to you.

Current Medications:

Medication:________________________________
Dosage:_______________Frequency:__________
Route: ________________

Medication:________________________________
Dosage:_______________Frequency:__________
Route: ________________

Medication:________________________________
Dosage:_______________Frequency:__________
Route: ________________

Medication:________________________________
Dosage:_______________Frequency:__________
Route: ________________

Medication:________________________________
Dosage:_______________Frequency:__________
Route: ________________

Medication:________________________________
Dosage:_______________Frequency:__________
Route: ________________

Post-Surgery Medications:

Medication:___________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:___________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:___________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:___________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:___________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:___________________________________
Dosage:_______________Frequency:____________
Route: ________________

****During the course of your Physical Therapy, if there are *any changes* (type or dosage) in your medications or supplements, it is important that you notify your therapist!****

I certify to the best of my knowledge, that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/ practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/ practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co- managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature:__________________________________ **Date:** __________________

Reviewed with Patient:____ **Date:** __________________

Evaluating Registered Dietitian's Signature:_____________________________ **Date:** __________________