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 _____

Medical History Questionnaire

dba/Progress Rehabilitation Network, LLC ("Progress")

Patient Name _____**Phone (day)** _____**Phone (evening)** _____

Address_____**City/State/Zip**_____**DOB**_____

Email address _____**Primary Physician**_____

Emergency Contact_____**Relationship**_____**Phone**_____

Currently Employed ☐ Yes ☐ No ☐ Retired **If Yes, Occupation/Employer** _____

Additional information related to employment_____

Why did you select our facility? ☐ Medical Provider Referral ☐ Returning Patient ☐ Family/Friend ☐ Web/Internet
☐ Workshop ☐ Newsletter ☐ Other _____ ☐ If Medical Provider, please list name_____ _____

Please check any of the following that apply to you:

☐ Pain	☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes
☐ Numbness/Tingling	☐ Circulation Problems	☐ Blood Clots	☐ Ehlers-Danlos Syndrome
☐Osteoarthritis	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Other Arthritic Conditions
☐ Multiple Sclerosis	☐ Epilepsy	☐ Stroke/CVA (Date) _____	☐ MRSA
☐ Asthma	☐ Emphysema/Bronchitis	☐ Tuberculosis	☐ Hepatitis
☐ Dizziness/Fainting	☐ Recent Fever	☐ Stomach Ulcers	☐ Depression

☐ Alcohol/Drug Dependence
☐ Cancer If yes, describe _____
☐ Heart Problems_____
☐ Kidney Problems _____
☐Allergies/sensitivities

Please check any of the following you have experienced in the last 12 months:

☐ Easy Bruising	☐ Joint/Muscle Swelling	☐ Skin Rash
☐ Nausea/Vomiting	☐ Excessive Bleeding	☐ Problems Sleeping
☐ Fatigue	☐ Difficulty Breathing	☐ Sexual Difficulties
☐Weakness	☐ Regular Cough	☐ Urinary Incontinence
☐ Fever/Chills/Sweats	☐ Arm/Leg Swelling	☐ Problems Urinating
☐ Stress at Home or Work	☐ Heart Racing in your Chest	☐ Fecal Incontinence
☐ Tremors	☐ Difficulty Swallowing	
☐ Seizures	☐Heartburn/Indigestion	
☐ Double Vision	☐Constipation/Diarrhea	
☐ Loss of Vision	☐ Blood in Stool	
☐ Eye Redness	☐ Blood in Urine	

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? ☐ Yes ☐ No

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

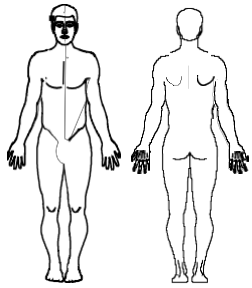
During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If Yes, estimated delivery date _____ Is your pregnancy considered high risk? ☐ Yes ☐ No

Medical History Questionnaire

dba/Progress Rehabilitation Network, LLC ("Progress")



Do you have complaints of pain or other symptoms? ☐ Yes ☐ No If yes:

Draw in the body chart to the right where you have pain or other symptoms

What makes your pain better? _____

What makes your pain worse? _____

In the past week, how much has pain interfered with your daily activities (work, social, household)?

No interference **<** 0------1------2------3------4------5------6------7------8------9------10 **>** Unable to carry out daily activities

Check all that apply ☐ Pain no relived by rest ☐ Pain at night ☐ Dizziness/Fainting

☐ Recent Infection/Fever ☐ Recent fall with or without injury

Who have you seen for recent complaints of pain or other symptoms? ☐ None ☐ Physician ☐ Physical Therapist

☐ Acupuncturist ☐ Chiropractor ☐ Other: _____

For Exercise/Yoga/Pilates/Meditation Clients,

Please list any important information we should consider for development of your exercise program

_____

_____

List any positions you need to avoid or modify for exercise, yoga and meditation

_____

For Massage Clients

Have you had a professional massage before?

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/Deep Tissue

Other_____

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

If yes, please explain_____

What are your goals for massage? _____

PROCEDURES / SURGERIES: ☐ NONE ☐ BELOW

DATE	TYPE	DATE	TYPE

Medical History Questionnaire

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CURRENT MEDICATIONS: ☐ **NONE** ☐ **BELOW** ☐ **LIST ATTACHED**

Please list ALL medications that you are **currently** taking **or** attach a copy of your own list. (**Include** prescription, over-the-counter, and vitamin/nutritional supplements). For each medication, list the name, dosage, frequency and route (mouth, inhaler, intravenously, topically, etc).

MEDICATION	DOSE	FREQUENCY	ROUTE

If you are a patient at Progress Physical Therapy, LLC, please sign here if you allow a physical therapist on staff to discuss your medical history and recommendations with any physical therapy, wellness or fitness professional working at Progress Physical Therapy, LLC, including physical therapist, massage therapist, health coach, registered dietitian, pilates instructor, yoga instructor, or personal trainer.

Signature: _____ Date: _____

CANCELLATION - Kindly provide at least 24-hours' notice if you are unable to keep an appointment so that we may offer that time to another client. Missed appointment fees may apply if 24 hours' notice is not provided.

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this provider/practitioner/instructor immediately whenever I have changes in my health condition. I consent to my provider/practitioner/instructor to contact my physician, if indicated.

Client/Guardian Signature _____ Date _____

Printed Name _____

PT/Instructor Initial Review (Date & Initial) _____

PT/Instructor Updated (Date & Initial) _____ PT/Instructor Updated (Date & Initial) _____

BY SIGNING THIS DOCUMENT, YOU ARE WAIVING CERTAIN LEGAL RIGHTS. PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING.

RELEASE AND INDEMNITY AGREEMENT

I, the undersigned, as a patient, client or guest of Progress Physical Therapy, LLC (an affiliate of Progress Rehabilitation Network, LLC), its affiliated companies, and its and their directors, owners, employees, agents, and insurers (hereinafter referred to as PROGRESS), agree that if I engage in any physical exercise, or activity on the premises, or any location, I do so at my own risk, regardless of fault, and ***I FULLY RELEASE, DEFEND, INDEMNIFY, HOLD HARMLESS AND FULLY DISCHARGE*** *PROGRESS from any and all liabilities, damages and claims, or causes of action of any kind or description to me, my personal representatives, assigns, heirs, and next of kin for any damage to or loss of property any injury to me or my death or any one or more of the foregoing, arising directly or indirectly out of my participation in any program or out of treatment provided or advise/instruction given by PROGRESS. This includes without limitation the use of the building, equipment, parking area, and stairs, and includes my participation in any programs (including Pilates, Massage Therapy, Restore, FAST, Pneuweight Unloading, yoga, meditation, golf evaluation/swing analysis, health coaching, nutrition counseling, running analysis, strength training movement analysis, and all Physical Therapy Treatments), instructions, evaluations, and screenings. I agree that I am participating voluntarily and acknowledge that I may incur pain, soreness and possible injury while participating in the normal course of this any program or treatment and that it is* ***MY RESPONSIBILITY TO INFORM THE CLINICIAN OR INSTRUCTOR IMMEDIATELY*** *should I experience any of these symptoms.*

This waiver and release of all liability includes but is not limited to injuries or death which may result from improper use of exercise equipment, my use of equipment which may malfunction and/or break or any other unspecified injury ***WHETHER OR NOT SUCH CLAIM FOR DAMAGE, LOSS, INJURY OR DEATH ARE CAUSED OR CONTRIBUTED TO BY THE SOLE OR CONCURRENT NEGLIGENCE, OMISSION, STRICT LIABILITY, OR FAULT OF PROGRESS AND WHETHER OR NOT CAUSED BY A PRE-EXISTING CONDITION.***

I WARRANT THAT I HAVE CAREFULLY READ THIS *DOCUMENT AND KNOW ITS CONTENTS, AND THAT I HAVE EXECUTED THIS DOCUMENT VOLUNTARILY AND AS MY OWN FREE ACT. I EXECUTE THIS DOCUMENT FULLY INTENDING TO BE BOUND BY ITS TERMS.*

Executed to be effective as of the date set forth below.

Signature (of Guardian, if participant is under 18 years old)_____

Printed Name_____

Date_____

PROGRESS is not responsible for injury resulting from the performance of any exercise routines. These training methods are only a recommendation. All exercise is performed at your own risk. Check with your personal physician before starting a new physical routine.