rehab dynamics
PHYSICAL THERAPY

PAST MEDICAL HISTORY

Patient Name_____ Today's Date _____

Are you presently working? ___Yes ___No Date of next doctor appointment? _____

Date of injury/onset_____ Have you ever had these symptoms before? ___Yes ___No

Check which apply to your symptoms:

___Work related injury ___ Recurrence of previous injury ___Cause unknown
___ Motor vehicle injury ___ Injury related to lifting ___ Athletic/recreational injury

Have you had related surgery? ___Yes ___ No If yes, what was the date of surgery? _____

Circle below if you have, or have you had any of the following?

Diabetes	Allergies to aspirin	Smoking
Chest pain/angina	Allergies to heat	Liver/gallbladder problems
High blood pressure	Allergy/intolerance to cold	Asthma/breathing difficulty
Heart disease	Other allergies	Bowel and Bladder problems
Heart attack	Hernia	Special Diet Guidelines
Heart palpitations	Seizures	Rheumatoid arthritis
Pacemaker	Metal implants	Ringing in ears
Headaches	Dizziness/fainting	Nausea/vomiting
Kidney problems	Recent fractures	Surgeries
Are you pregnant?	Cancer	Skin abnormalities

If you circled "yes" on any of the above, please briefly explain and give an approximate date:

Are you presently taking any medications? ____YES ____ NO If yes, please list the medication and for what condition:

Rate the intensity of your pain on a scale of 1-10 (1 being no pain, 10 being the worst possible) _____

HIPPA

Right to revoke: you will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the owner. Please understand that revocation of this consent will not affect any action we took in reliance on consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Please print your name, _____, have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that by signing this consent form, I am giving my consent to you to use and disclose my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date:_____

Personal Representatives Name: _____ Relationship to patient: _____

I give you permission to share my personal information with the following people:
Name:_____ Relationship: _____
Name:_____ Relationship: _____

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Marketing Release Form

From time to time, photos/videos/testimonials/patient result forms will be acquired from patients. Photos will be from staff events, sponsored community events, office celebrations and general clinic activities. We will not use any information specifically relating to your treatment plan.

Rehab Dynamics requests your permission to use this information in any of the following marketing channels: website, patient newsletter, social media websites or informational brochures.

We at Rehab Dynamics would like to promote you as our patient and the great work you do with our therapists. All materials (photo, video, etc.) will be taken by a Rehab Dynamics staff member.

____Yes, I grant Rehab Dynamics Physical Therapy permission to use my material for marketing purposes. Materials may be used in any of the following facets: website, patient newsletter, social media website or informational brochures.

___No, please do not use my photos.

_____
Print name

_____ _____
Signature Date

Rehab Dynamics, LLC Coronavirus Disease 2019
Patient & Employee Questionnaire

Name: _____ Date: _____

You will be asked to complete this form at each visit or to verbally confirm that there have been no changes in your answers since the initial form completion. Employees will attest to absence of symptoms or exposure twice a day.

Please check the Yes or No boxes; do not check both boxes. Feel free to explain what a yes or no answer means in the Comment Section below the question.

1. Have you traveled outside this city or town in the past 30 days? Yes ☐ No ☐
   If yes, please list the countries, states or towns you have visited below.
   Comment: _____

2. Have you been in close contact (≤ 6 feet for ≥ 15 minutes) with an individual who has traveled outside of this city or town in the last 48 hours? Yes ☐ No ☐
   If yes, please list the countries, states or towns he/she has visited below.
   Comment: _____

3. Have you been in close contact with an individual who has had any of these symptoms, in the past 14 days?

☐ Fever over 100.4° or chills	Yes ☐ No ☐
☐ Persistent cough	Yes ☐ No ☐
☐ Shortness of breath/difficulty in breathing	Yes ☐ No ☐
☐ Fatigue	Yes ☐ No ☐
☐ New loss of taste or smell	Yes ☐ No ☐
☐ Sore throat	Yes ☐ No ☐
☐ Muscle or body aches	Yes ☐ No ☐
☐ Congestion or runny nose	Yes ☐ No ☐
☐ Nausea or vomiting	Yes ☐ No ☐
☐ Diarrhea	Yes ☐ No ☐
☐ Headaches	Yes ☐ No ☐

   If yes, have they been diagnosed and/or seen the doctor? Yes ☐ No ☐

4. Have you had any these symptoms in the past 14 days?

☐ Fever over 100.4° or chills	Yes ☐ No ☐
☐ Persistent cough	Yes ☐ No ☐
☐ Shortness of breath/difficulty in breathing	Yes ☐ No ☐
☐ Fatigue	Yes ☐ No ☐
☐ New loss of taste or smell	Yes ☐ No ☐
☐ Sore throat	Yes ☐ No ☐
☐ Muscle or body aches	Yes ☐ No ☐
☐ Congestion or runny nose	Yes ☐ No ☐
☐ Nausea or vomiting	Yes ☐ No ☐
☐ Diarrhea	Yes ☐ No ☐
☐ Headaches	Yes ☐ No ☐

   If yes, how long have you had these symptoms? _____
   If yes, have you been diagnosed and/or seen the doctor? Yes ☐ No ☐

If you answered yes to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability; if you are a provider we will enforce work restrictions as indicated by the CDC or your personal physician.

Please contact _____ at _____ if you have questions. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019: