Progress Physical Therapy

Registration Form

Date: _____

Full Name: _____

Address:

(number and street) _____

(City, State, Zip Code) _____

Phone: (for cancellation/rescheduling, when needed)

Home: _____

Cell: _____

Email Address: _____

___ Check here if you do not want to be on our email list for occasional announcements related to classes/new services at Progress Physical Therapy

5300 Hickory Park Dr., Suite 110
Glen Allen, VA 23059
804-270-7754

Progress Physical Therapy, LLC

Medical History Questionnaire

To assist your therapist in completing a thorough evaluation, please provide us with all medical background information. If you do not understand a question, please leave it blank and your therapist will assist you.

Name: _____

Occupation:_____

Leisure Activities: _____

ALLERGIES: List any medications you are allergic to: _____

Are you latex sensitive? ☐ Yes ☐ No List any other allergies we should know about: _____

_____

Please check any of the following whose care you are under:

☐ Medical Doctor (MD) ☐ Psychiatrist/Psychologist ☐ Other: _____
☐ Osteopath ☐ Physical Therapist _____
☐ Dentist ☐ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, routine physical, etc.):

_____

_____

Check if you have **EVER** been diagnosed as having any of the following conditions?

☐ Blood Clots
☐ High Blood Pressure
☐ Circulation Problems
☐ Asthma
☐ Chemical Dependency (i.e. Alcoholism, Prescription Medication)
☐ Diabetes
☐ Multiple Sclerosis
☐ AIDS
☐ MRSA
☐ Rheumatoid Arthritis
☐ Thyroid Problems
☐ Tuberculosis
☐ Stroke
☐ Stomach Ulcers
☐ Emphysema/Bronchitis
☐ Epilepsy
☐ Depression
☐ Ehlers-Danlos Syndrome
☐ Hepatitis
☐ Other Arthritic conditions
☐ Osteoporosis

☐ Cancer If Yes, describe what kind & treatment _____
☐ Heart Problems If Yes, describe what kind & treatment _____
☐ Kidney Disease If Yes, describe what kind & treatment _____

Other _____

Do you have a pacemaker? ☐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

Progress Physical Therapy, LLC

Medical History Questionnaire

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
☐ Cancer
☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
☐ Stroke
☐ Depression
☐ Osteoporosis

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

Date	Reason for Surgery/Hospitalization	Date	Reason for Surgery/Hospitalization
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Please describe all significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date of injury.

Date	Injury	Date	Injury
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

How much caffeinated coffee or other caffeinated beverage do you drink per day? _____
How many packs of cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____
Have you ever taken steroid medications for any reason? _____
Have you ever taken an anticoagulant? _____

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

☐ Weight Loss
☐ Weight Gain
☐ Nausea/Vomiting
☐ Fatigue
☐ Weakness
☐ Fever/Chills/Sweats
☐ Numbness or Tingling
☐ Tremors
☐ Seizures
☐ Double Vision
☐ Loss of Vision
☐ Eye Redness
☐ Skin Rash
☐ Problems Sleeping
☐ Sexual Difficulties
☐ Night Sweats
☐ Easy Bruising
☐ Joint/Muscle Swelling
☐ Dizziness/Lightheadedness
☐ Excessive Bleeding
☐ Difficulty Breathing
☐ Regular Cough
☐ Arm/Leg Swelling
☐ Heart Racing in your Chest
☐ Difficulty Swallowing
☐ Heartburn/Indigestion
☐ Constipation/Diarrhea
☐ Blood in Stool
☐ Post Menopause
☐ Problems Urinating (difficulty starting, painful, etc.)
☐ Urinary Incontinence
☐ Blood in Urine
☐ Hearing Problems
☐ Stress at Home or Work

Progress Physical Therapy, LLC

Medical History Questionnaire

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.

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

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!****

Patient Signature: _____ Date: _____

Reviewed with Patient: _____ Date: _____

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, Injury Prevention, Pneuweight Unloading, 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. . THIS AGREEMENT SHALL BE GOVERNED AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE COMMONWEALTH OF VIRGINIA, WITHOUT REGARD TO PRINCIPLES OF CONFLICT LAWS.*

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.