MEDICAL SCREENING QUESTIONNAIRE

Thank you for selecting Resurgent Sports Rehab to provide your medical care or for your sports performance needs. To best serve you, please read the following questions carefully and answer with your best possible accuracy.

Date: _____

First Name: _____ Last Name: _____ Date of Birth: ____/____/_____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

E-Mail: _____ Can we send appointment reminders via email? Yes No

Occupation: _____ Employer: _____

Did a Physician refer you? ☐ Yes ☐ No If yes: Name: _____Phone: ( ) _____

Emergency Contact Name: _____ Relationship: _____ Phone: ( ) _____

How did you hear about us? ☐ Website ☐ Physician ☐ Website ☐ Current Client _____

☐ Friend/Family _____ ☐ Run Group/Team _____ ☐ Other _____

INSURANCE INFORMATION

Insurance Company: _____ Phone: ( ) _____

Policy #:_____ Group #:_____

Policy Holder Name: _____ Policy Holder DOB: _____Relationship:_____

Resurgent Sports Rehab is an out-of-network provider.
Payment is due at the end of each visit. Resurgent Sports Rehab provides claim forms for you that can be mailed directly to your insurance company for any out-of-network reimbursements.
Medicare claims are submitted electronically via Resurgent Sports Rehab.

PAST MEDICAL HISTORY:

Have you had any medical problems or hospitalizations in the past year? ☐ Yes ☐ No

If "yes", please specify: 1. _____

2. _____

3. _____

Surgical History: Procedure: _____ Date: _____

Procedure: _____ Date: _____

Have you experienced any injuries prior to your current problem? ☐ Yes ☐ No

	Location of Pain	Date of Injury	Treatment received	Recovery Time
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Have you ever been diagnosed with any of the following conditions? Please check any that apply.

☐ Asthma	☐ High Blood Pressure	☐ Heart Attack	☐ Heart Disease	☐ Cancer
☐ Infection	☐ Chemical Dependency	☐ Depression	☐ Kidney Disease	☐ Nervous Disorder
☐ Diabetes	☐ Metal/other implant	☐ Emphysema	☐ Eating Disorder	☐ Osteoporosis
☐ Arthritis	☐ Circulatory Disease	☐ Stroke	☐ Thyroid Problems	☐ Tuberculosis
☐ Hernia	☐ Blood Clot (DVT)	☐ Hepatitis	☐ Epilepsy	☐ Angina/Chest Pain

Has anyone in your family been diagnosed with any of the above conditions? ☐ Yes ☐ No
Please specify: _____

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

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If Yes, please list: _____

CURRENT HEALTH STATUS:

How would you rate your general health (check one)? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate your current diet (check one)? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Would you be interested in a nutritional consult? ☐ Yes ☐ Maybe ☐ No

Do you get seven or more undisturbed hours of sleep a night? ☐ Yes ☐ No

Have you noticed any changes in your mood or ability to concentrate in the past 6 months? ☐ Yes ☐ No

If yes, please describe: _____

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

During the past month, have you lost interest or pleasure in doing things? ☐ Yes ☐ No

Is this something with which you would like help? ☐ Yes ☐ No ☐ Yes, but not today

Current Prescription Medications: _____

Current Over-the-counter Medications: _____

For women only: Any recent changes in menstruation? ☐ Yes ☐ No Are you currently pregnant ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, please specify years: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, please specify: amount/day, week, or month: _____

Have you noticed any of the following within the past 3 months (check all that apply)?

☐ Change in appetite	☐ Increased pain at night	☐ Difficulty initiating urination	☐ Headaches
☐ Weakness	☐ Fever/chills/sweats	☐ Unexplained weight change	☐ Dizziness
☐ Fainting	☐ Numbness or tingling	☐ Balance problems (Falls)	☐ Diarrhea
☐ Constipation	☐ Recent Infection	☐ Urinary freq or painful changes	☐ Change in urine color
☐ Fatigue	☐ Nausea/vomiting	☐ Heartburn/indigestion	☐ Nonhealing sores/wounds
☐ Incontinence	☐ Sexual dysfunction	☐ Shortness of breath	☐ Pain with sexual intercourse
☐ Heart palpitations	☐ Difficulty swallowing	☐ Ringing in the ears	☐ Cough with sputum

PRESENT INJURY/PROBLEM:

Date of Injury/Onset: _____ Body Part(s):_____

Have you been treated for this condition or are you currently receiving treatment? ☐ Yes ☐ No

If yes, Provider Name: _____ Group Name: _____

Have you received any imaging or diagnostics for your current problem? ☐ Yes ☐ No

If yes, please specify type and date: _____

☐ I understand that I will need a prescription from a doctor to continue with physical therapy after 30 business days per VA State Law

THE PATIENT-SPECIFIC FUNCTIONAL SCALE:

Identify up to three important activities that you are unable to do or are having difficulty with as a result of your current injury or condition. Then score the activity on a 0-10 scale where 0 represents the inability to perform the activity and a 10 represents your ability to perform the activity at the level as before your injury or problem.

Activity	Score (0-10)
1. _____	_____
2. _____	_____
3. _____	_____

Please mark the areas where you feel symptoms on the chart below and describe your symptoms.

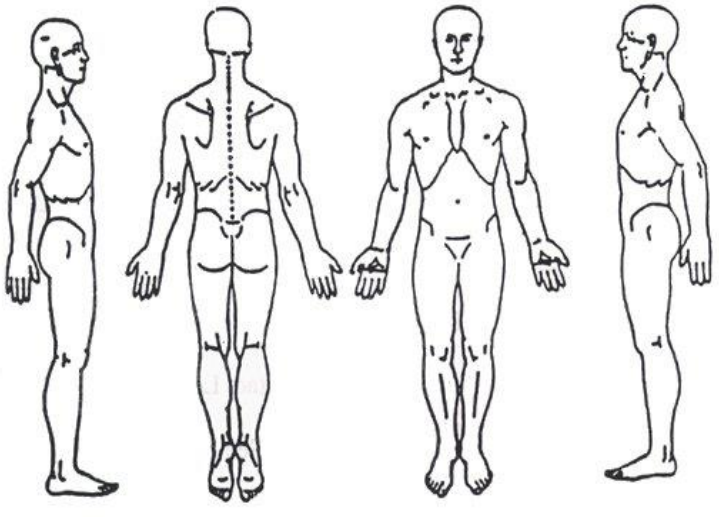
How would you describe your pain? **Circle all that apply:**

Stabbing Aching Dull Constant Burning Radiating Intermittent Tingling Numb Squeezing
Other: _____

Pain Level

0 1 2 3 4 5 6 7 8 9 10

How old are your current running shoes? _____
Do you wear orthotics? _____
Races this past year? _____
Upcoming Races? _____
Other exercise training? _____



Resurgent Sports Rehab

Statement of Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW OU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

We may contact you by phone, mail, or email. It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

» You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

» You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

» You have the right to inspect and copy your health information.

» You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

» You have a right to receive an accounting of disclosures of your protected health information made by us.

» You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (703) 279-853-6106.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Fast Track Physical Therapy & Sports Performance with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date

No Show, Cancellation, and Reschedule Policy

As a patient/client of **Resurgent Sports Rehab**, we ask that you please give us at least 24 hour notice for any cancellations or rescheduling. If you inform us of your need to cancel via email or phone with less than 24 hours of your appointment, you will incur a **$75** Cancellation/Reschedule Fee (subject to change without prior notice). If you do not attend your scheduled appointment, you will be charged the same **$75** fee.

In the unlikely event that **Resurgent Sports Rehab** needs to cancel or reschedule your appointment, you will not be charged the $75 cancellation fee.

By signing below, you acknowledge that you have been informed of this policy.

_____ _____

Signature Date

Informed Consent

I give Resurgent Sports Rehab consent to photograph, videotape and record my image and/or voice to be used in marketing purposes including internet, website, social media, company newsletters, etc. I further understand that no special compensation will be provided to me for use of my image and that I may not be informed in advance of the specific use of my image.

(If 17 years old or younger please have parent or guardian sign.)

_____ _____

Signature Date

8500 Executive Park Ave, Ste 100
Fairfax, Virginia 22031
https://resurgentsports.com