Rover Rehab

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Preferred Language: _____ Do you require an interpreter? _____

What sex were you assigned at birth? _____

Emergency Contact Information

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____

Employment/School Information

Employer: _____ Job Title: _____

Length of time employed prior to injury: _____

Current Status: Full-Time | Part-Time | Unemployed | Disabled | Housework | Work @ Other Employer

If Enrolled as Student, Name of School: _____

Degree/Study Being Pursued: _____

Projected Graduation Month & Year: _____

Case Management Information; Representation

Are you obtaining services today without referral from a physician, employer, attorney/lawyer, or case manager?

Yes | No

If you are represented by a case manager, please identify your type of case:

Workers' Compensation | Auto Accident | Personal Injury | Other

Other: _____

Medical Status

Do you smoke? Yes | No How many packs per day do you smoke? _____

Are you pregnant? Yes | No

Please list any allergies: _____

Have you tested positive for Covid-19 within the past 6 months?

Yes | No Date(s) tested positive: _____

Are you currently experiencing symptoms consistent with cold/flu/Covid-19? (fever, runny nose, sneezing, congestion, cough, sinus pressure/headache, sore throat, loss of smell or taste)

Yes | No

Have you been in close proximity/contact with someone who has tested positive for Covid-19 within the past 10 days?

Yes | No

Medical History

In the past month, please place a check next to any and all symptoms you have experienced

___ Fatigue	___ Nausea/Vomiting	___ 5lb+ Weight Change	___ Numbness/Tingling
___ Constipation	___ Fever/Chills	___ Pain at Night	___ Appetite Changes
___ Visual Changes	___ Difficulty Swallowing	___ Rapid Heart Rate	___ Bowel/Bladder Changes
___ Incontinence	___ Dizzy/Light Headed	___ Frequent Headaches	___ Unexplained Cough
___ Fainting	___ Muscle Weakness	___ Shortness of Breath	___ Urinary Tract Infection

Please list your previous surgeries + dates of surgeries:

_____ _____

_____ _____

_____ _____

Please list your current medications (if more space is needed, please write the remainder on the back):

_____ _____

_____ _____

_____ _____

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

___ Anemia	___ Pneumonia	___ High/Low Blood Pressure	___ Back Pain (Herniation, Stenosis, Degenerative Disc)
___ Asthma/Allergies	___ Stroke/CVA/TIA	___ Lung Disease/ COPD/ ARDS	___ GI Disease (Liver, Ulcer, Hernia, Reflux, Gallbladder)
___ Bone/Joint Infections	___ Diabetes (Type 1 or 2)	___ Bladder/ Urinary/ Kidney Disease	___ Vascular Disorders/ Blood Clots/ DVTs
___ Cancer	___ Thyroid Disorder	___ Osteoarthritis/ Rheumatoid Arthritis	___ Depression/ Anxiety/ Panic Disorders
___ Chest Pain/Angina	___ Seizures/Epilepsy	___ Congestive Heart Failure/ Heart Attack	___ Neurological Disease (Parkinson's, MS, etc.)
___ Migraines	___ TB/ HIV/ Hepatitis A/B/C	___ Visual/Hearing Impairments	___ Other(s)

Other(s) _____

Authorization to Release Information

Family members, friends, or other contacts patient will allow to receive and/or discuss case information and/or personal health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Attorney and/or Case Manager:

Attorney: _____ Law Firm: _____

Address: _____ Phone: _____

Case Manager: _____ Phone: _____

Workers' Compensation Company: _____

I authorize the aforementioned family members, friends, or other contacts to receive and/or discuss my case information and/or personal health information. I further authorize my attorney and/or case manager to have access to my case information and personal health information. I understand that I do not have to list names or relationships of individuals who will receive my case information and/or personal health information. I understand the details of dissemination of my personal health information can be found, at length, in Rover Rehab's Privacy Policy and Privacy Practice documents to which I have access and have been offered a copy of.

Patient/Guardian Signature _____ Date _____

Privacy Notice

I, the undersigned, do hereby acknowledge for myself (or on behalf of the patient in my capacity as authorized representative of the patient identified for this case), that Rover Rehab has made me aware of the legal duties, policies, and procedures regarding the protection of my (or the patient's) personal health information. I further affirm that I have been offered a copy of Rover Rehab's notice of privacy practices describing these policies and protections, and also acknowledge that a copy of Rover Rehab's notice of privacy practices is available on the Rover Rehab website: https://www.rover-rehab.com. I understand and agree that, unless I request otherwise in writing, Rover Rehab will communicate with me via phone, fax, and/or email, and will state the company name (Rover Rehab) when leaving messages for me (or the patient) via any of these means.

Rover Rehab will never communicate or otherwise provide medical advice via answering machine, voicemail, messages with family members, email, or fax.

I acknowledge and understand that I may contact Rover Rehab's Compliance Officer and/or Privacy Officer should I have questions or comments regarding Rover Rehab's privacy practices at **(803) 510-5229** or **trey@rover-rehab.com**.

I hereby certify that the medical history provided is true and accurate to the best of my knowledge. I further acknowledge that I have read and understand the consents, authorizations, and policies as described above.

Electronic Signature Disclaimer: If signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Patient/Guardian Signature _____ Date _____