Blue Sky Physical Therapy
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Risk Factor & Medical History

Name: _____Date of Birth: _____Date of Injury: _____

Living Environment: ☐ House ☐ Apartment ☐ Married ☐ Single ☐ Divorced

Are you in ___ Excellent, ___ Very Good, ___ Fair, or ___ Poor Health?

Please check all of the conditions that apply to you either presently or in the past:

____None of these		
____High/Low Blood Pressure	____Low Blood Sugar	____Asthma
____Osteoporosis/Osteopenia	____Psychiatric Problems	____Lung Disease
____Diabetes	____Nausea/Vomiting	____Bleeding Disorders
____Cancer	____Shortness of Breath	____Night Sweats
____Smoking	____Sharp Heavy Pressure in Chest	____Rheumatoid Arthritis
____Stroke	____Pacemaker	____Osteoarthritis
____Memory Loss	____High Cholesterol	____Epilepsy/Seizures
____Pregnant/Possibly Pregnant	____Hernia	____Vertigo/Dizziness
____Circulatory Problems	____Skin Disease/Allergies	____None of these

____Allergies – please list: _____

____Other – please list: _____

Do you have a family history of the following?_____Heart Disease_____Arthritis _____Cancer

Please list any Surgeries or other conditions for which you have been hospitalized:

Date	Surgery/Hospitalization	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications you are taking and what they are for:

_____

_____

Please list any restrictions from your physician or work: _____

What activities in your normal day are you unable to perform due to your current injury? What are your specific physical therapy goals?

_____

_____

Depression Screening:

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes or No
2. During the past month, have you often been bothered by little interest or pleasure in doing things? Yes or No

Signature: _____Date: _____