Blue Sky Physical Therapy, PC

Blue Sky Pilates and Wellness, INC

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