

Blue Sky Physical Therapy

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Risk Factor & Medical History

Name: _____ Age: ____ Date of Birth: _____

Occupation: _____ Date of Injury: _____

Please list any restrictions from your physician: _____

Please list any restrictions from your work: _____

Is there any litigation/insurance settlement pending regarding this injury? ___ Yes ___ No

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

- | | | |
|---|--|---|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Sharp Heavy Pressure in Chest | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Pregnant/Possibly Pregnant | <input type="checkbox"/> Hernia | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Skin Disease/Allergies | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Allergies – please list: _____ | | |
| <input type="checkbox"/> 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:

List any adverse reactions to drugs: _____

What activities in your normal day are you unable to perform due to your current injury?

What are your therapy goals?

Signature: _____ Date: _____