Skyline PHYSICAL THERAPY

1504 Iowa Street, Bellingham, WA 98229
P.O. Box 28306, Bellingham, WA 98228
(360) 738-4300 fax: (360) 738-8010
www.skyline-physicaltherapy.com

MEDICAL HISTORY

Patient Name: _____ Date: _____

Please describe the primary symptoms you are seeking treatment for today? _____

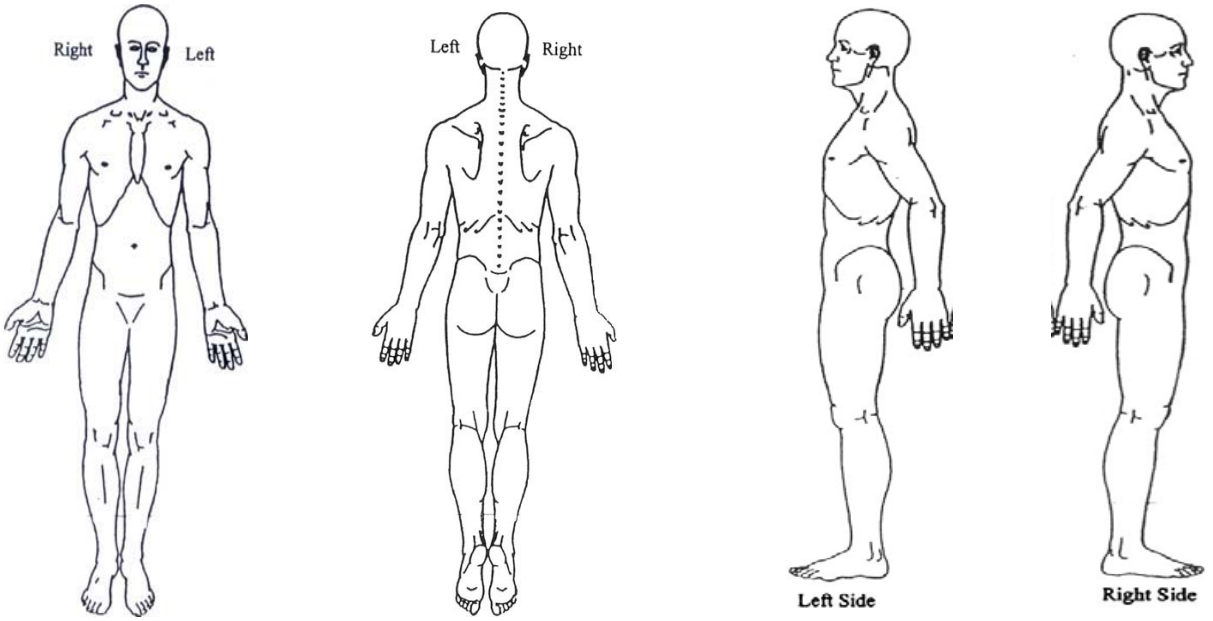
_____

When did your symptoms begin? _____

Have you previously been treated with physical therapy for this condition? _____

If yes, describe when and if treatment helped: _____

Please indicate on the body chart where you experience your symptoms.



Please rate your pain from 0-10 (0 = No Pain, 10 = Emergency Room Pain):

Pain at best = _____ Occurs during: _____

Pain at worst = _____ Occurs during: _____

My symptoms are: Best in the ❑ AM ❑ PM Worst in the ❑ AM ❑ PM Do not change ❑

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Please list 3 things you are unable or have difficulty doing due to your symptoms: _____

_____

Please indicate if you or your parents/siblings have or have ever had any of the following: Mark S for Self and F for immediate family next to any marked conditions.

	S	F		S	F		S	F
❑ Asthma _____			❑ Skin issue/Psoriasis _____			❑ Epilepsy / Seizures _____		
❑ Lung Problems _____			❑ Headache/Migraine _____			❑ Thyroid Disorder _____		
❑ Emphysema _____			❑ Stroke _____			❑ Kidney Stone _____		
❑ Pacemaker _____			❑ Osteoporosis _____			❑ High Blood Pressure ____		
❑ Heart Disease _____			❑ Depression _____			❑ High Cholesterol _____		
❑ Osteoarthritis _____			❑ Diabetes _____			❑ Neurologic Disorder _____		
❑ Rheumatoid Arthritis ____			❑ Cancer _____			❑ Chemical Depend _____		

Check appropriate box if you have any of the following:

❑ Anxiety	❑ Decreased Sensation	❑ Unexplained Fatigue
❑ Shortness of Breath	❑ Changes in Bowel	❑ Falls / Imbalance
❑ Dizziness / Blackouts	❑ Changes in Bladder	❑ Head Injury
❑ Difficulty swallowing	❑ Recent illness /Infection	❑ Bruise easily
❑ Changes in Vision	❑ Loss of Appetite	❑ Women: if pregnant
❑ Night Pain	❑ Recent Weight loss	

Do you smoke? _____ Packs per day: _____

Please list any allergies: _____

List current medications and others recently taken: _____

_____

List previous surgeries and fractures: _____

_____

Please list tests and results (X-rays MRI, CT scan, EMG, Other): _____

_____

What would you like to achieve with physical therapy? _____

Patient Signature: _____