SKYLINE HEALTH

Rehabilitation Services Medical History Form

Patients are responsible for knowing their insurance benefits.

Have you had physical therapy this year? ❑ Yes ❑ No		If yes, list how many visits:	
Full Legal Name:	Preferred name:	Date of birth:	Gender:
Mailing address:	City:	Zip code:	
Physical address:	City:	Zip code:	
Home phone:	Cell phone:		
Social Security number:	Email:		
Marital status:	Spouse/Parent/Guardian's name & date of birth:		
Emergency contact name & relation to patient:	Emergency contact phone:		
Primary Care Physician:	Employer:		

For Patients with Medicare

Date of retirement or disability:	Date of spouse's retirement, if applicable:

For Worker's Compensation or Motor Vehicle Accident Claims

Patient's condition related to: ❑ Employment ❑ Auto ❑ Other:		
Have you had physical therapy for this injury? ❑ Yes ❑ No		If yes, list number of visits:
Name of insurance company:		
Date of injury:	Claim number:	State where accident occurred:
Name of claims adjuster:	Phone:	Fax:
Employer at time of injury:		Employer's phone:
Employer's address:		

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Are you currently under the care of any of the following?

❑ Medical doctor ❑ Osteopath ❑ Naturopath ❑ Psychiatrist ❑ Physical therapist ❑ Chiropractor
❑ Neurologist ❑ Other:

Have you or any of your immediate family members been diagnosed with any of the following conditions?

You	Family		You	Family		You	Family	
❑	❑	High blood pressure	❑	❑	Cancer	❑	❑	Asthma
❑	❑	Multiple sclerosis	❑	❑	Diabetes	❑	❑	Stroke
❑	❑	Chemical dependency	❑	❑	Hepatitis	❑	❑	Anemia
❑	❑	Arthritic conditions	❑	❑	Emphysema	❑	❑	Depression
❑	❑	Anorexia/bulimia	❑	❑	Tuberculosis	❑	❑	Kidney disease
❑	❑	Thyroid problems	❑	❑	Epilepsy/seizure	❑	❑	HIV/AIDS
❑	❑	Osteoporosis	❑	❑	Other:			

Allergies:

List any past surgeries/injuries/hospitalizations:

List any prescriptions or over the counter medications you are currently taking:

Please rate your pain on a scale from 0 – 10 (0 = no pain, 10 = worst pain imaginable)

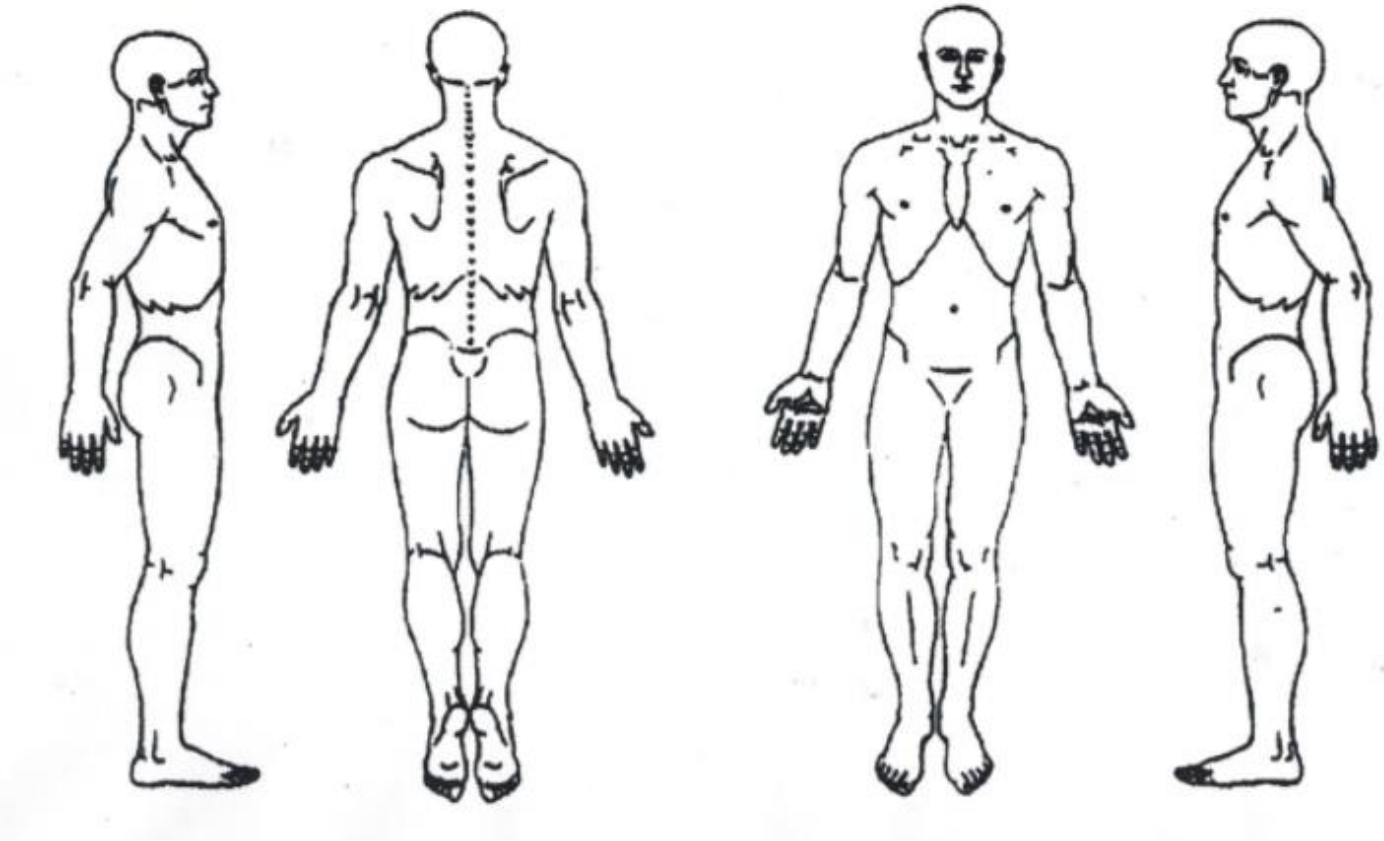
0 1 2 3 4 5 6 7 8 9 10

Have you had images taken for this injury?

❑ X-rays ❑ MRI ❑ CAT Scan ❑ Ultrasound ❑Other:

If yes, please list the name of the facility where images were taken:

Please mark the areas of involvement:



Please circle the number below which bests represents your average level of function:											
Cannot do anything	0	1	2	3	4	5	6	7	8	9	10	Able to do everything

What would you like to be able to do after physical therapy that you cannot do now?

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