SKYLINE HOSPITAL

PHYSICAL THERAPY AND SPORTS MEDICINE

SINCE THE ONSET OF YOUR CURRENT SYMPTOMS, HAVE YOU HAD?

Bowel or bladder dysfunctions	YES	NO	Fever/Chills	YES	NO
Numbness in genital or anal area	YES	NO	Numbness	YES	NO
Dizziness or fainting	YES	NO	Weakness	YES	NO
Unexplained weight change	YES	NO	Night pain/sweats	YES	NO

Do you smoke cigarettes or use chewing tobacco?	YES	NO
Do you drink coffee or caffeinated beverages?	YES	NO
Do you drink alcohol?	YES	NO

1. PLEASE MARK YOUR PAIN LEVEL

0 _____ 10

No Pain — Worst pain Imaginable

2. PLEASE MARK YOUR FUNCTIONAL EVERY DAY ACTIVITIES LEVEL

0% _____ 100%

Unable — All Normal Activities

3. PLEASE MARK YOUR FUNCTIONAL WORK LEVEL

0% _____ 100% **Occupation:** _____

Unable — All Normal Activities

4. PLEASE MARK YOUR RECREATIONAL / SPORT ACTIVITY LEVEL

0% _____ 100% **Activity:** _____

Unable — All Normal Activities

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IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR INSURANCE BENEFITS

DATE YOU RETURN TO PHYSICIAN? _____ **HAVE YOU HAD PHYSICAL THERAPY IN 2015**_____

DATE OF INJURY/SURGERY? _____ **CLAIM #**_____

Name: _____ Birth Date: _____ SSN: _____

Mailing Address: _____ City: _____ State: Zip: _____

Contact Phone: _____ Physical Address: _____

Email address: _____

Employer: _____ Address: _____ Work Phone: _____

Are you married? Yes No Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact : _____ **Relationship to Patient:** _____ **Contact Phone:** _____

FOR MEDICARE: DATE OF RETIREMENT: _____ **DATE OF SPOUSE RETIREMENT:** _____

MEDICAL HISTORY

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 immediate family member 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_____

Any Surgeries /Injuries?/ Hospitalizations?_____

_____

_____

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

_____

_____

_____