



6650 W. 44th Ave Wheat Ridge, CO 80033 · 303-993-9767 · holisticpt.net

Risk Factor and Medical History

Name: (Last, First, MI) _____ DOB: _____

Date of Injury: _____ Date of Surgery: _____

Living Environment: (circle one) House or Condo/Apartment
(circle one) Do you live alone? Or with family?

How would you describe your health? (circle one) Excellent or Very Good or Fair or Poor?

Please check all of the conditions that apply to you currently or in the past?

- | | | |
|---------------------------|----------------------------|----------------------------|
| None of These _____ | Pregnant _____ | Skin Disease _____ |
| High Blood Pressure _____ | Circulatory Problems _____ | Asthma _____ |
| Low Blood Pressure _____ | Low Blood Sugar _____ | Lung Disease _____ |
| Osteoporosis _____ | Psychiatric Problems _____ | Bleeding Disorders _____ |
| Osteopenia _____ | Nausea _____ | Night Sweats _____ |
| Diabetes _____ | Shortness of Breath _____ | Rheumatoid Arthritis _____ |
| Cancer _____ | Chest Pain _____ | Osteoarthritis _____ |
| Smoking _____ | Pacemaker _____ | Epilepsy/Seizures _____ |
| Stroke _____ | High Cholesterol _____ | Vertigo/Dizziness _____ |
| Memory Loss _____ | Hernia _____ | |

Allergies? Please List: _____

Other? Please List: _____

Do you have a family history of the following? Heart Disease ___ Arthritis ___ Cancer ___

Please list any surgeries or illnesses for which you have been hospitalized. Include date, reason for hospitalization and surgery performed:

List all Medications and reason for taking them (or provide separate list):

Please list any restrictions from your physician or work: _____

What activities in your daily life are you currently unable to do? _____

During the past month, have you often been bothered with feeling down, depressed or hopeless? **Yes** or **No**

During the past month, have you had little interest or pleasure in doing things? **Yes** or **No**

Signature: _____ Date: _____