History and Physical Condition Information

Name: _____ Age:_____
Referring Physician: _____ Today's Date: _____

Primary Care Physician: _____Phone: _____

Problems to be treated: _____

Approximately when did your injury start?_____

Have you had treatment for this problem before? YES NO
If YES, state where: _____ When:_____
Treatment given: _____
Have you had surgery associated with this problem? YES NO

What is your current height: _____ current weight: _____

Please list *all* medications on the separate *Medication list* form:

Do you now have / or have you ever had any of the following:

High Blood Pressure	YES	NO	Sensitive to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO	Other Illnesses	YES	NO
Cancer	YES	NO	Describe_____		
History of Smoking	YES	NO			

If YES on any of the above, please explain and give approximate dates:_____
_____

Have you had Physical Therapy before for any injury? YES NO If YES, when and for how long?_____

Are you pregnant? YES NO

Please provide your intended goals for Physical Therapy involving your current injury.
_____

The above information is correct to the best of my knowledge.

Signature: _____
Date: _____

Orthosport Physical Therapy