

Yorba Linda Physical Therapy History and Physical Condition Information

Answers to the following questions will assist your Therapist in providing a safe and effective treatment plan.

NAME: _____ Today's Date: _____

Primary Care Physician _____ Phone: _____

Problems to be treated: _____

Have you had treatment for this problem before? YES NO
If yes, state where: _____
Treatment given: _____

Have you had surgery associated with this problem? YES NO
If yes, please list date and type of surgery: _____

Are you currently taking any medication? YES NO
If YES, please list all medications: _____

Do you have (currently or previously) any of the following:

High blood pressure	YES	NO	Sensitivity 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	Osteoporosis	YES	NO

List any allergies or sensitivity to tape, latex or iodine: _____

List any other major illness or surgery that has occurred in the past year: _____

Have you ever had Physical Therapy? YES NO

Are you pregnant? YES NO

Do you need assistance with any of the following:

Transportation	YES	NO	Meals	YES	NO
Shopping/Errands	YES	NO	Personal Care	YES	NO
Domestic Chores	YES	NO	Other	_____	

Has your illness/disability caused any of the following:

Financial Problems	YES	NO	Family Problems	YES	NO
Emotional Problems	YES	NO	Other	_____	

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

Signature: _____ Date: _____