

## 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: \_\_\_\_\_