11201 S. Eastern Ave #220
Henderson, NV 89052
Phone: (702) 614-0324
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HISTORY AND PHYSICAL CONDITION INFORMATION

Answers to the following questions will assist the therapist in providing a safe and effective treatment program.

Name: ___________________________________
Age: ___________ DOB: ____________

Referred by:
☐Physician ☐Insurance Company
☐ Friend ☐ Other

Referring Physician or Primary Care Physician: _________________________________

Physician Phone Number:____________________

Problem to be treated: _________________________________

Have you had treatment for this problem before?
☐ YES ☐ NO

If YES, state when: ____________________________

Where did you receive treatment: ________________

Have you had surgery associated with this problem?
☐ YES ☐ NO

If YES, state when: ____________________________

Are you currently taking any medications?
☐ YES ☐ NO

Do you now have/or have you ever had any of the following:
☐ High Blood Pressure
☐ Heart Disease
☐ Heart Attack
☐ Pacemaker
☐ Diabetes
☐ Kidney Problems
☐ Lung Disease
☐ Cancer
☐ Seizures
☐ Neurological Disorders
☐ Balance Problems
☐ Frequent Falls
☐ Sensitivity to Heat/Ice
☐ Headaches
☐ Dizzy Spells
☐ Allergies
☐ Hernia
☐ Metal Implants
☐ Vision Problems
☐ Hearing Problems

Have you ever had physical therapy before?
☐ YES ☐ NO

Are you pregnant?
☐ YES ☐ NO

If YES, please list all medications?
____
____
____

List any other major illness, or surgery that has occurred in the past one year:
____
____
____

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

Signature: __________________________________ Date: ____________________