70 E. Horizon Ridge Pkwy #180
Henderson, NV 89002
Phone: (702) 856-0422
Fax: (702) 433-0425

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

If YES, please list all medications?

_____
_____
_____

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

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: _____