

***University City*** Physical Therapy & ***FunctionSMART*** Fitness  
**History and Physical Condition Information**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_  
Reason for Therapy: \_\_\_\_\_  
Date of Onset/Injury: \_\_\_\_\_  
Commenced as a Result of: \_\_\_\_\_  
\_\_\_\_\_

Have you had any 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 \_\_\_\_\_

Do you have any of the following:

Pain	YES ___ NO ___	Swelling	YES ___ NO ___
Headaches	YES ___ NO ___	Loss of Movement	YES ___ NO ___
Fatigue	YES ___ NO ___	Sensitive to Heat/Ice	YES ___ NO ___
Nausea/Dizziness	YES ___ NO ___	Numbness	YES ___ NO ___
Tingling	YES ___ NO ___		

High Blood Pressure	YES ___ NO ___	Heart Problems	YES ___ NO ___
Pacemaker	YES ___ NO ___	Circulation Problems	YES ___ NO ___
Kidneys Problems	YES ___ NO ___	Nervous Problems	YES ___ NO ___
Diabetes	YES ___ NO ___	Seizures	YES ___ NO ___
Hernia	YES ___ NO ___	Allergies	YES ___ NO ___
Metal Implants	YES ___ NO ___	Pregnancy	YES ___ NO ___

Are you presently taking Medications      YES      NO  
Please List \_\_\_\_\_  
\_\_\_\_\_

Are you working? \_\_\_\_\_  
How is your problem limiting your daily activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Undersigned acknowledges and agrees that the information set forth is true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
7/15/2006