CONDITION AND HISTORY

Client Name: _____ Date of Birth: _____

Your Condition or Injury: _____ Date of Onset: _____

What happened? Briefly describe your current concerns: _____

_____

_____

Is this condition related to auto accident, other accident, or employment?……Yes No

Do you have an attorney or advocate?……Yes No

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Prior Hospitalizations/Surgeries: _____

_____

_____

Medications: _____

Allergies: _____

Equipment / Vendor: _____

Circle any past or current medical conditions you may have

Arthritis	Cancer	Cardiac / Heart Disease
Cardiovascular Disease	Diabetes	Gout
High Blood Pressure	Head Injury	Lung disease
Neck and Back Pain	Pacemaker	Stroke

Other (please list): _____

Do you have a history of falling?.....Yes No

Do you have dizziness or vertigo? ..... Yes No

Do you have balance problems?..... Yes No

NOTE: If you are currently pregnant or think you might be, please inform your therapist.

Occupation: _____ Currently able to work? Yes No

Areas of concern at work: _____

Areas of concern at home: _____

Recreational activities/hobbies: _____

Currently able to perform? Yes No

Have you, or are you, receiving therapy services previously? If so, where, from whom and how long?

_____

_____

In an effort to provide the most effective therapy services, please list what are the areas of function that you would like to see change over the course of therapy. In other words, let's assume that therapy is over and you are deciding whether treatment was successful. What are the improvements that would make you say "Yes, that was worth the time, money and effort I put into it?"

_____

_____

Is there anything you feel we should know that we have not asked? If yes, please explain:

_____

_____