



Patient Name: _____ Age: ____ Date: _____

Have you ever been diagnosed with and/or treated for any of the following? If so, please provide additional information in the space provided for any questions answered “YES.”

	YES/NO	COMMENTS
1. Diabetes If yes, diet or insulin controlled?	_____	_____
2. Cardiac (heart) conditions, high blood pressure, pacemaker, history of rheumatic fever, vascular disorders	_____	_____
3. Arthritis; if yes, what type?	_____	_____
4. Pulmonary (lung) disease, i.e. bronchitis, asthma, emphysema, COPD, tuberculosis	_____	_____
5. Intestinal Disorders	_____	_____
6. Seizure disorders, epilepsy, convulsions	_____	_____
7. CVA (stroke) paralysis	_____	_____
8. Cancer, if yes, what type	_____	_____
9. Previous orthopedic injuries, broken bone, sprain/strain, Surgery	_____	_____
10. Problems with eye, ears, nose	_____	_____
11. Thyroid and/or gland disorders	_____	_____
12. Skin disease/disorders	_____	_____
13. Allergies to any medications/ substances	_____	_____
14. Alcohol/Drug Dependency	_____	_____
15. Mental/Nervous Disorders	_____	_____
16. Birth Defects/Deficits	_____	_____
17. Reproductive System Disorder, menstruation disorder, Currently Pregnant	_____	_____
18. Medications currently taking	_____	_____

Additional Comments: _____

I acknowledge that I have received a Privacy Practice Notification from Urban Physical Therapy, Inc. and further by signing below I provide permission to use and disclose my medical information for the permitted purpose of treatment, payment, and healthcare operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____