CREST
PHYSICAL THERAPY

Patient Medical History

Patient Name ______________________________ **ID #:** ____________ **Date:**____________

Referring Physician: ______________________________ **Family Physician:** ______________________________

Regarding this injury: First Doctor Visit: / / Last day Worked: / / Date Returned to Work: / /

Have you had surgery for this injury? ❒ YES ❒ NO Took place in: ❒ Hospital ❒ Surgery Center Is an attorney involved in this case? ❒ YES ❒ NO

Number of surgeries: _______ Type of Surgery: ______________________________

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO		YES	NO
Massage Therapy	______	______	CT Scan	______	______	Neurologist	______	______
General Practitioner	______	______	EMG/NCV	______	______	Myelogram	______	______
Occupational Therapy	______	______	MRI	______	______	Chiropractor	______	______
Emergency Room Care	______	______	Podiatrist	______	______	Orthopedist	______	______
Physical Therapy	______	______	X-Rays	______	______	Other: ____________	______	______

Have you had two (2) or more falls, or any fall resulting in injury, in the past year? _____YES _____ NO

If yes, please explain: ______________________________

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Shortness of Breath/Chest Pain	______	______	Heart Attack or Surgery	______	______
Vision or Hearing Difficulties	______	______	Weakness	______	______
Coronary Heart Disease or Angina	______	______	Stroke/TIA	______	______
Numbness or Tingling	______	______	Weight Loss/Energy Loss	______	______
Do you have a Pacemaker?	______	______	Congestive Heart Disease	______	______
Dizziness or Fainting	______	______	Hernia	______	______
High Blood Pressure	______	______	Blood Clot/Emboli	______	______
Bowel or Bladder Problems	______	______	Varicose Veins	______	______
Emotional/Psychological Problems	______	______	Anemia	______	______
Thyroid Disease or Goiter	______	______	Joint Replacement Surgery	______	______
Any Pins or Metal Implants	______	______	Epilepsy/Seizures	______	______
Cancer or Chemotherapy/Radiation	______	______	Diabetes	______	______
Sleeping Problems/Difficulties	______	______	Allergies	______	______
Do you use tobacco?	______	______	Are you pregnant?	______	______
Infectious Diseases Neck: ❒ Injury ❒ Surgery	______	______	Shoulder: ❒ Injury ❒ Surgery	______	______
Arthritis Back: ❒ Injury ❒ Surgery	______	______	Elbow/Hand: ❒ Injury ❒ Surgery	______	______
Osteoporosis Knee: ❒ Injury ❒ Surgery	______	______	Gout in Leg/Ankle/Foot: ❒ Injury ❒ Surgery	______	______

Smoking Status: Every Day Smoker ❑ Some Day Smoker ❑ Former Smoker ❑ Never Smoker ❑ Unknown ❑

List any other information that would assist us in your care, i.e. recent surgeries, etc: ______________________________

____

____

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Are you aware of your diagnosis and prognosis as explained by your doctor? ❒ YES ❒ NO

Based on your awareness, what are your rehabilitation expectations/goals while in this program?

____

____

Would you like to speak to a social worker about any aspects of your rehabilitation program? ❒ YES ❒ NO

Please list the following Medications you are taking below:

Drug Name *(including OTC, herbals, vitamins)*	Dosage *(mg, units, etc.)*	Frequency *(once a day, etc.)*	Route *(oral, topical, etc.)*

Are you allergic to any medications? ❒ YES ❒ NO

If yes, list Medications: ____

Patient/Guardian Signature: ______________________________________ Date: ______________

OFFICE USE ONLY

Intake Reviewed by: ______________________________________ Date: ______________

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