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CRUX REHABILITATION
Pinnacle of Quality Care

PATIENT HISTORY FORM

NAME:_____
DOB:_____
DATE:_____

What are we seeing you for today?:

_____
_____
_____

Date of injury/onset of symptoms: _____

Is the condition accident related? If yes, date of accident? _____

Were you injured at job? If yes, Date and mechanism of injury?

_____
_____
_____

Are you currently working? Full-time/Part-time/ Modified activity: _____

Have you had X-rays/MRI /CT-Scan/EMG/Bone Scan? (Circle one if applicable)

Are you pregnant? ☐ Yes ☐ No

Have you been hospitalized for this problem? ☐ Yes ☐ No Dates: ___/___/___ - ___/___/___

Do **you** currently have, or have you ever had any of the following conditions?

	NO	YES	
Cancer	☐	☐	_____
High Blood pressure	☐	☐	_____
Heart problems	☐	☐	_____
Asthma	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid problems	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Arthritis	☐	☐	_____
Depression	☐	☐	_____
Stroke	☐	☐	_____
Epilepsy	☐	☐	_____
Hepatitis	☐	☐	_____
Difficulty walking	☐	☐	_____
Osteoporosis	☐	☐	_____
Fibromyalgia	☐	☐	_____
Pacemaker	☐	☐	
Weakness in arms and legs	☐	☐	_____
Chemical dependency	☐	☐	_____
Joint Pain or Swelling	☐	☐	_____
Coordination Problems	☐	☐	_____

Crux Rehabilitation
333 University Ave #150
Sacramento CA 95825
Phone: 916-669-9038 Fax: 916-529-4161

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Other	☐	☐	_____
Other Metal Implant	☐	☐	_____

Any recent health changes (i.e., significant weight gain/loss; bowel/bladder problems; fever; dizziness; changes in vision and/or speech, etc)? _____

Please list any previous injuries or surgeries

_____

_____

_____

Are you taking any medications? Please list _____

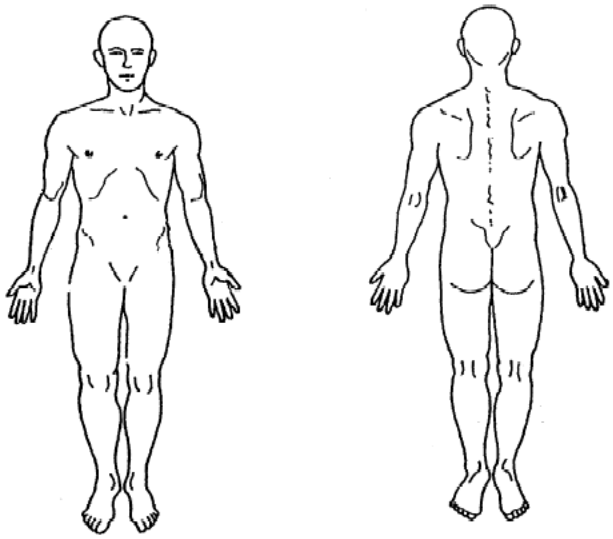
Any Allergies? Please list

_____

_____

Please rate your pain(circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst pain (would go to ER)

- Shade areas of pain on the body
- Place xx's on the body to indicate areas of numbness, tingling or burning



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