Schuyler Hospital Rehabilitation Patient History

Name: ______________________________ Date: __________ Age: _____ Date of Birth: ______________
Referring Physician: __________________________ EMAIL:____

Have you had therapy for any reason since January of this year? **YES** **NO** **NOT SURE**

HISTORY OF PRESENT PROBLEM, ILLNESS OR INJURY

What is the problem/injury you are here for today? ____
When did this problem start? ________________________
Is this a work related injury? ______________ If so, are you currently working?__________________________
Is this injury related to a motor vehicle accident? _____________

What makes your symptoms ***better***? ____
What makes your symptoms ***worse***? ____

Have you had any of the following tests/studies **related to this condition?**

Facility	*Facility*
X-RAY___________________________	**Discogram**__________________
MRI____________________________	**EKG**_________________________
CT Scan_______________________	**Other**________________________
EMG/NCV_____________________	

Are you currently employed? Yes No Occupation: ______________________________
Current activity restrictions **set by your doctor**: ____
Do you participate in a regular exercise program? Yes No Frequency per week: _______________________

PAST MEDICAL HISTORY

Check all that apply

Smoker	Cancer	Arthritis
Currently Pregnant	Fractures	Depression/Anxiety
High Blood Pressure	Falls	Diabetes
DVT/Blood Clots	Pacemaker	Angina
Heart Disease/Heart Attack	Asthma	Thyroid Problems
High Cholesterol	Allergies	COPD
Stroke	Osteoporosis	Dizziness
Pulmonary Embolism	Kidney Disease	Metal Implants
Liver Disease	Seizures	Other______________________

Please list all of your previous surgeries: ____
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MEDICATIONS

Please list all medications you are currently taking: (Please disregard if you provided a copy of medications)

_____________________ _____________________ _____________________ _____________________
_____________________ _____________________ _____________________ _____________________