

Name: _____

Date: _____

Age: _____ Sex: M F Height: _____ Weight: _____ Dominant hand: R L

SCHOOL INFORMATION: Grade: _____ School: _____

WORK INFORMATION: Do you have a job: Y N If yes, job: _____

SPORT INFORMATION: Current sport(s) and/or activities: _____

Position(s) played/event(s): _____ How long have you been playing: _____

Team name(s): _____

HISTORY OF INJURY: How did your problem occur?: _____

Date of Onset: _____ Involved Side: R L Both Next Physician Follow-up: _____

Describe any previous problems with this area: _____

MEDICAL INFORMATION: Family Physician: _____

Referring Physician: _____ Diagnosis: _____

Medical Tests: X-Ray___ CT Scan___ Bone Scan___ MRI___ EMG___ NCV___ ImPACT___
Arthrogram___ Ultrasound___ Other: _____ Results: _____

Did you have surgery? Y N Date: ___/___/___

Did you use: Cast ___ Splint___ Brace___ Boot___ Date Used: ___/___/___ - ___/___/___

Do you drink or smoke: Y N **Females:** Have you started menstruating? Y N Age of first period: ___

Have you ever been diagnosed with any of the following conditions?

<input type="checkbox"/> Y	<input type="checkbox"/> N	Cancer (Type: _____)	<input type="checkbox"/> Y	<input type="checkbox"/> N	Juvenile Rheumatoid Arthritis
<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart or Circulation Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Other Arthritic Conditions
<input type="checkbox"/> Y	<input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mononucleosis
<input type="checkbox"/> Y	<input type="checkbox"/> N	Depression/Anxiety/OCD (Circle)	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ehler's Danlos/Hypermobility
<input type="checkbox"/> Y	<input type="checkbox"/> N	Asthma (Worse with: _____)	<input type="checkbox"/> Y	<input type="checkbox"/> N	Latex Allergy
<input type="checkbox"/> Y	<input type="checkbox"/> N	Allergies	<input type="checkbox"/> Y	<input type="checkbox"/> N	Anemia
<input type="checkbox"/> Y	<input type="checkbox"/> N	Disordered Eating	<input type="checkbox"/> Y	<input type="checkbox"/> N	Osteoporosis/Osteopenia/Stress fractures
<input type="checkbox"/> Y	<input type="checkbox"/> N	Urinary Leakage/Pelvic Floor Issues	<input type="checkbox"/> Y	<input type="checkbox"/> N	Lyme disease
<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Learning disability/ADHD
<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes (Type I/II)	<input type="checkbox"/> Y	<input type="checkbox"/> N	Concussion (#: _____)

Please turn over and complete the other side



List any medications (including prescriptions, over-the-counter, herbals, vitamin/mineral/dietary supplements) you are currently taking:

Name of Med./Supplement	Dosage	Frequency of Use	Route of Administration
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

FUNCTION:

Circle or list any activities that you have difficulty completing (walking, sitting, running, standing, climbing stairs, sports, school, lifting, carrying, throwing, squatting, cutting, pivoting, jumping, sleeping, dressing, reaching):

What are your goal(s) for Physical Therapy? _____

PAIN: (select your pain level from the following number OR face scales)



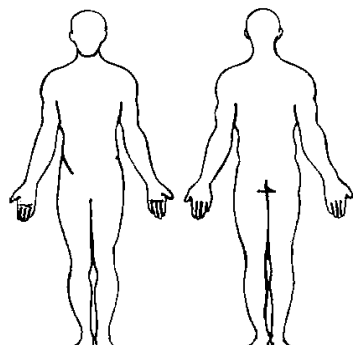
Circle the amount of your pain at best- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
 Circle the amount of your pain at worst- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
 Amount of pain with rest _____ (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
 Amount of pain with activity _____ (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Is your pain: Constant _____ Intermittent _____
 Since the onset of pain, is your pain: Improving _____ Worsening _____ Unchanged _____
 Describe your pain: sharp, achy, dull, sore, numb, tingling, burning, clicking, popping, locking, catching, other: _____

Activities that increase pain: _____
 Activities that decrease pain: _____

Please mark on the drawing and/or lists below the areas where you feel your pain:

- Head/neck: Y N
- Upper/mid back: Y N
- Low back: Y N
- Shoulders: Y N
- Elbows: Y N
- Wrists/hands: Y N
- Hips: Y N
- Knees: Y N
- Ankles/feet: Y N
- Other: Y N



Other Concerns/Questions: _____

Please tell us how you heard about us!

Please circle your response below (please circle all that apply):

Family physician/pediatrician

Specialist/orthopedist

Other medical provider (neurologist, rheumatologist, dentist, orthodontist, chiropractor, etc)

Athletic trainer

Coach

Massage therapist

Friend or family member

Flyer or other marketing material

Prior patient

Injury prevention program with your sports team

Other: _____

Please tell us the name of your referral source so we can thank them:
