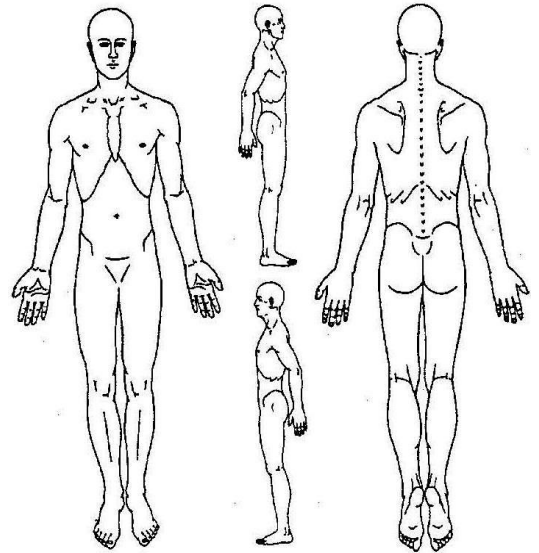


SportsCare

Physical Therapy

"For the Athlete in All of Us"



Date: _____ Name: _____

Date of birth: _____ Height: _____ Weight: _____

Date of symptom onset, injury or surgery: _____

Please indicate on the diagram where your pain is located. Briefly describe how the injury occurred (home/work/sports/school/MVA) and your current symptoms: _____

(If work related) Employer and job title: _____

Currently working: Yes / No Work restrictions: _____

Pre-injury lifting requirements: Lift (pounds): _____ Push (pounds): _____ Pull (pounds): _____

Please circle and label your (C) current pain level, (W) worst pain level and (L) least pain level experienced this week:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain)

List specific activities and/or times of the day that makes your pain worse: _____

Have you had any of the following tests performed for this problem?

X-ray MRI CT Scan Bone Scan Arthrogram Lab Tests Other: _____

Do any of the following conditions apply to your past or current state of health?

- | | | | | |
|---|---------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Angina | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> COPD | <input type="checkbox"/> Systemic Disease | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Irregular Heartbeats/Murmurs | <input type="checkbox"/> Pregnant | <input type="checkbox"/> HIV | | |

Please list any past surgeries/injuries you have had (relevant to current injury) with date: _____

Please list all prescription and non-prescription medications you are currently taking: _____

Have you had previous physical therapy for this injury? Yes / No? Where? _____

What are your expectations/goals of treatment? _____

How did you hear about SportsCare Physical Therapy or Armworks Hand Therapy?

Doctor Referral Friend/Family Repeat Patient Website Google Yelp Facebook Instagram
 Email HS Athletic Trainer: _____ Event: _____ Other: _____