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:_____

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 ____Nerve Conduction_____

Arthrogram___ ImPACT___ Other:______________Results:_______________________________

Did you have surgery? Y N Date:_____/_______/_________

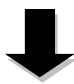
Did you use: Cast ____Splint___ Brace___ Date Applied:___/___/____ Date Removed___/___/____

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?

__Y __N Cancer
__Y __N Heart or Circulation Problems
__Y __N High Blood Pressure
__Y __N Depression/Anxiety/OCD
__Y __N Asthma
__Y __N Allergies
__Y __N Eating Disorder
__Y __N Thyroid Problems
__Y __N Diabetes
__Y __N Lyme's Disease
__Y __N Juvenile Rheumatoid Arthritis
__Y __N Other Arthritic Conditions
__Y __N Hepatitis
__Y __N Stroke
__Y __N Latex Allergy
__Y __N Anemia
__Y __N Osteoporosis/Osteopenia/Stress fractures
__Y __N Multiple Sclerosis
__Y __N Learning disability
__Y __N Concussion

Please turn over and complete the other side



KINETIC Physical Therapy
adolescent sports medicine

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:

Indicate 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 goals 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 _____ Amount of pain with activity ______

Is your pain: Constant____ Intermittent____
Since the onset of pain, is your pain: Improving____ Worsening_____ Unchanged____

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