KINETIC PHYSICAL THERAPY
adolescent sports medicine

TMJ

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: Night guard ___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	Juvenile Rheumatoid Arthritis
__Y	__N	Heart or Circulation Problems	__Y	__N	Other Arthritic Conditions
__Y	__N	High Blood Pressure	__Y	__N	Hepatitis
__Y	__N	Depression/Anxiety/OCD	__Y	__N	Stroke
__Y	__N	Asthma	__Y	__N	Latex Allergy
__Y	__N	Allergies	__Y	__N	Anemia
__Y	__N	Eating Disorder	__Y	__N	Osteoporosis/Osteopenia/Stress fractures
__Y	__N	Thyroid Problems	__Y	__N	Multiple Sclerosis
__Y	__N	Diabetes	__Y	__N	Learning disability
__Y	__N	Lyme's Disease	__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 (chewing, eating, talking, working, smiling, laughing, school work, sports, throwing, sleeping)

_____

What are your goals for Physical Therapy? _____

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

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____

Do you have: Ringing in the ears Clicking Locking Grinding Headaches Popping

Activities that increase pain (please circle): chewing, eating hard foods, eating soft foods, sleeping, talking, smiling, laughing, exercising, drinking, social activities, recreational activities, self-care, stress, work, 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