Advanced Manual Therapy and Sports Rehabilitation
at The Sports Medicine Clinic

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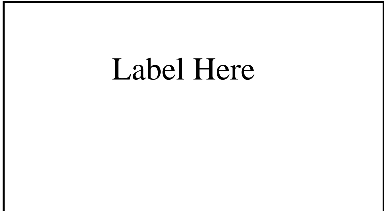

Name ____ Date ____________________

Phone # Home__________________Work___________________Cell__________________________
E-Mail Address____
Date of Birth_______________ Age__________ Height___________ Weight_______________
Primary Physician_________________________________

Use of Alcohol: Never ____ Rarely____ Moderate____ Daily____
Use of Recreational Drugs: Never____ Rarely ____ Moderate ____ Daily____ Type____________________
Use of Caffeine: Cups per Day____ Coffee____ Tea______ Sodas____
Use of Tobacco: Never____ Previously, but quit____ Current pack/day____
Exercise: Never____ Rarely____ Weekly____ Daily____ Type of Exercise__________________________

Current Occupation:__________________________ Employer: ______________________________

REASON FOR VISIT:____ Date of Onset:_________
How did your problem begin?
____Motor Vehicle Accident ____Work Related Injury ____Sports/Training Injury
____Unknown Cause _____ Post-Surgical ____Chronic Illness/Condition
____Other____

Frequency of pain/symptoms: 1-2x/Day ____3-4x/Day ____ 4 or more x/Day ____Constant _____
Has this condition/injury prevented you from working? No____ Yes______ How Long? __________________

What increases your symptoms? (Check all that apply)
Sitting ____Standing ____Walking ___Lying Down ___Reaching overhead ___Pushing ____Pulling ____
Lifting ____ Running ____Jumping ____Squatting ____Throwing ____Bending Forward _____
Coughing/Sneezing _____ Stress/Anxiety____Other:____________________________________

What decreased your symptoms? (Check all that apply)
Sitting ___Standing ___Walking ____Lying down ___ Heat ___Cold ___Rest ___Medication ___Massage___
Other: ____

Do you wake up at night secondary to pain? No____ Yes____ , how often__________
Have you received previous treatment for this condition?
No ____Yes_____, describe:____

Recent Tests (past 3 months):
X-Ray ___CT Scan ___MRI ___EMG ___Bone Scan ___Blood Tests ___ Arthrogram ___
Other ____

Please turn the page over to complete

Do you have a pacemaker? No ____ Yes____   Exercise Restriction? ___________________________________

Metal Implants? No____ Yes ____If yes,   where?___________________________

List any history of surgeries, hospitalizations, injuries (fractures, dislocations, sprains, etc…) – include date
Surgery____Date _______
Surgery____Date_______

Hospitalization? __________________Reason____

List ANY medications you are currently taking (including oral, injections, skin patches, etc…)__________________
____
List any Allergies:____

Have you ever been diagnosed or had any other the following conditions? (Check all that apply)

____Allergies
____Arthritis
____Anemia
____Asthma
____Balance Problems
____Bowel/Bladder Problems
____Bronchitis
____Cancer
____Chest Pain
____Circulatory Problems
____Depression/Anxiety/Panic
____Diabetes
____Dizziness/Fainting
____Emotional/Psychological Problems
____Emphysema/Bronchitis
____Epilepsy/Seizures
____Gout
____Headaches
____Heart Disease
____Hearing Problems
____Hepatitis
____Hernia
____High Blood Pressure
____HIV/AIDS
____Indigestion/Heartburn
____Infection (current only please)
____Insomnia/Sleep Loss
____Jaw Problems (TMJ)
____Kidney Problems
____Liver Disease
____Lung Problems
____Lupus
____Menstrual Problems
____Multiple Sclerosis
____Nausea/Vomiting
____Numbness/Tingling
____Osteoporosis/Osteopenia
____Pregnancy
____Seizures
____Sensitivity to heat/cold
____Shortness of breath
____Stroke
____Thyroid problems
____Tuberculosis
____Unusual fatigue or weakness
____Vision Problems
____Other_____________________

Check the amount of pain you have had in the last 24 hours:

No Pain ____ Pain Requiring ER
1 2 3 4 5 6 7 8 9 10

____
Patient Signature/Person Filling Out Form

____
Date

____
Therapist Signature

____
Date