



SPORTS MEDICINE FORM

Name:	_____
MR #:	_____
DOB:	_____
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female or Apply Patient Label

Today's Date: _____

Referral (please check):

- | | |
|--|--|
| <input type="checkbox"/> Physician: _____ | <input type="checkbox"/> Athletic Trainer: _____ |
| <input type="checkbox"/> Emergency Department: _____ | <input type="checkbox"/> Friend: _____ |
| <input type="checkbox"/> Urgent Care: _____ | <input type="checkbox"/> Website: _____ |
| <input type="checkbox"/> Physical Therapist: _____ | <input type="checkbox"/> Other: _____ |

Primary Care Physician: _____

Why are you being seen today? _____

When did the problem first begin? _____

Is the problem getting: worse better staying the same

Are you having pain? Yes No If yes, please describe the pain _____

What makes your condition worse? _____

Previous treatments? (i.e., physical therapy (location / duration), ice, rest, medications): _____

Allergies: _____

Current Medications: _____

Any health problems / previous injuries: _____

Previous Surgeries: _____

Family History (health problems of parents, siblings): _____

Social History:

School: _____ Grade: _____





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Sports History:

Sport/Position/Level _____ Hours per week _____ Years of Experience _____
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Review of Systems (check all that apply):

- [] Fever [] Vision problems [] Depression
[] Weight Loss [] Glasses [] Bleeding problems
[] Weight Gain [] Hearing problems [] Headaches
[] Growth Changes [] Dizziness [] Concussions
[] Diarrhea [] Ringing in ears [] Memory problems
[] Constipation [] Sinus problems [] Poor Coordination
[] Abdominal Pain [] Shortness of breath [] Balance problems
[] Chest Pain [] Asthma [] Numbness in arms/legs
[] Heart Problems [] Cough [] Menstrual Irregularity
[] High Blood Pressure [] Behavioral problems [] Pregnancy
[] Skin Rash/Eczema [] Sleep problems [] Eating/drinking problems

Explain Checked Items:

Parent/ Guardian Signature: _____ Date/Time: _____

Imaging:

Assessment:

Plan:

RTC: _____

Attending Signature: _____ Date/Time: _____