



## Sports Medicine Center for Young Athletes Patient Health and Sport Questionnaire

Name of Patient/Athlete: \_\_\_\_\_ Age: \_\_\_\_\_ MR: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Sports/Teams: \_\_\_\_\_  
 Coaches Names/Contact Info: \_\_\_\_\_  
 How did you hear about our clinic? Check all that apply:  
 Physician  NCS event  School Athletic Trainer  Media/TV  Other: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Date of surgery: \_\_\_\_\_  
 Please describe your injury: \_\_\_\_\_  
 \_\_\_\_\_

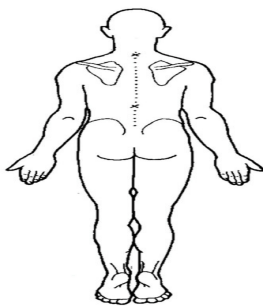
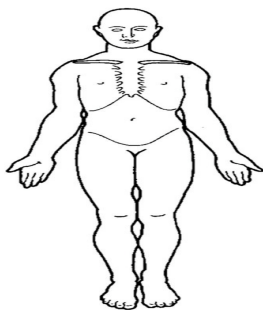
Regarding this injury, have you had an:  
 X-RAY  MRI  CT Scan  EMG  
 If yes, what are the results? \_\_\_\_\_

What treatment have you done for this injury previously (if any)?  
 \_\_\_\_\_

How has this injury limited your sport/activity? \_\_\_\_\_  
 \_\_\_\_\_

Please mark where you feel your pain/symptoms and describe them:  
 (circle all that apply)

Constant (always present) / Intermittent (comes and goes)  
 Sharp / Achy / Dull  
 Numb/Tingling /Shooting / Burning



Do you currently have, or have had in the past, any of the following conditions?

- yes  no Diabetes  
 yes  no Unexplained weight loss  
 yes  no Bowel / Bladder  
 yes  no Seizures  
 yes  no Hernia  
 yes  no Rheumatoid Arthritis  
 yes  no Allergies \_\_\_\_\_  
 yes  no Dietary concerns \_\_\_\_\_  
 yes  no Asthma \_\_\_\_\_  
 yes  no Previous Surgery \_\_\_\_\_  
 yes  no Immunizations up to date

Additional comments (medical or general health issues, any barriers to learning or communication?):  
 \_\_\_\_\_

Please list all medications you are currently taking:  
 \_\_\_\_\_

Please circle the number that best describes your pain:

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORSE POSSIBLE)

What makes your pain / symptoms better? \_\_\_\_\_  
 \_\_\_\_\_

What makes your pain / symptoms worse? \_\_\_\_\_  
 \_\_\_\_\_

What would you like to achieve with your rehabilitation program (sport goals, pain control, etc.)?  
 \_\_\_\_\_

Are you interested in a post-rehabilitation / sport specific training and conditioning program? Y / N

Email: \_\_\_\_\_

**Thank you for filling out this form. This will assist us in providing you with comprehensive care for your present injury.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of **parent / guardian** (if patient is under 17): \_\_\_\_\_ Date: \_\_\_\_\_

**Office use only:**

Clinician has reviewed and discussed with patient/caregiver: \_\_\_\_\_ Date: \_\_\_\_\_