



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: _____

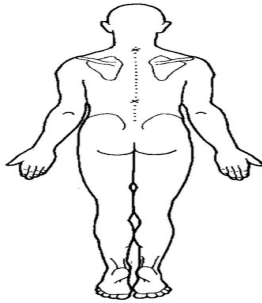
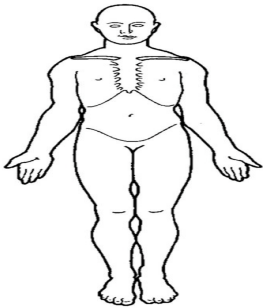
Regarding this injury, have you had an:
 X-RAY MRI CT Scan EMG
 If yes, what are the results? _____

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: _____