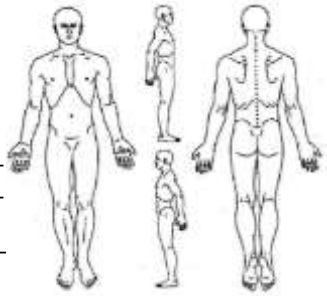
SPORTSCARE & ARMWORKS
PHYSICAL AND HAND THERAPY

Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Date of symptom onset, injury or surgery: _____

Please indicate on the diagram where your pain is located. Briefly describe how the injury occurred (home/work/sports/school/MVA) and your current symptoms:



_____

_____

(If work related) Employer and job title: _____

Currently working: Yes / No Work restrictions:_____

Pre-injury lifting requirements: Lift (pounds): _____ Push (pounds): _____ Pull (pounds):_____

Please circle and label your (C) current pain level, (W) worst pain level and (L) least pain level experienced this week:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain)

List specific activities and/or times of the day that makes your pain worse:

_____

_____

Have you had any of the following tests performed for this problem?

□ X-ray □ MRI □ CT Scan □ Bone Scan □ Arthrogram □ Lab Tests □ Other:_____

Do any of the following conditions apply to your past or current state of health?

□ Coronary Heart Disease	□ Heart Attack	□ Diabetes	□ Bowel/Bladder Problems	□ Epilepsy
□ Congenital Heart Disease	□ Stroke	□ Angina	□ Recent Weight Loss	□ Osteoporosis
□ Dizziness/Fainting	□ Hernia	□ Pacemaker	□ High Blood Pressure	□ Infectious Disease
□ Congestive Heart Failure	□ Cancer	□ Emphysema	□ Shortness of Breath	□ Asthma
□ Peripheral Vascular Disease	□ Allergies	□ COPD	□ Systemic Disease	□ Eating Disorder
□ Irregular Heartbeats/Murmurs	□ Pregnant	□ HIV		

Please list any past surgeries/injuries you have had (relevant to current injury) with date:

_____

Please list all prescription and non-prescription medications you are currently taking:

_____

Have you had previous physical therapy for this injury? Yes / No? Where? _____

What are your expectations/goals of treatment? _____

How did you hear about SportsCare Physical Therapy or Armworks Hand Therapy?

□ Doctor Referral □ Friend/Family □ Repeat Patient □ Website □ Google □ Yelp □ Facebook □ Instagram

□ Email □ HS Athletic Trainer: _____ □ Event:_____ □ Other: _____

Patient Signature: _____ Date: _____