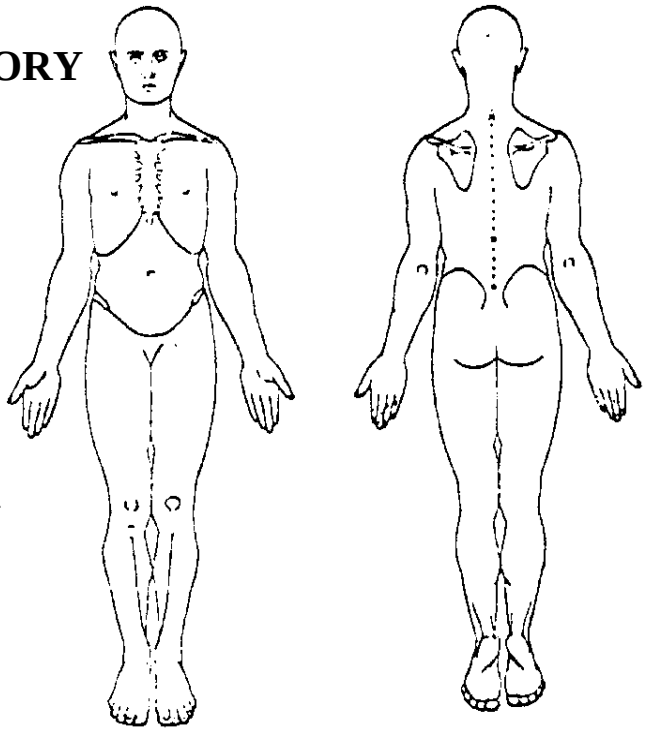
Sports Motion Physical Therapy

Enhances Motion & Prevents Injury

PATIENT HISTORY



1. Date when the injury/surgery occurred? _____

2. Where is your injury or pain? Be specific. (Please draw on diagram)

3. How did the injury or pain begin?

_____

4. What makes your pain worse? (List activities positions, posture)

_____

5. What makes your pain less? (List activities positions, posture)

_____

6. List current medications

_____

7. Do you have metal implants in your body? Where?

_____

8. Diagnostics tests please check:

☐ **X RAYS**	☐ **MRI**	☐ **CAT SCAN**
☐ **EMG**	☐ **ARTHROGRAM**	☐ **OTHER**

9. In the past 12 months have you been treated for the following?

☐ **Heart problems**	☐ **Blood pressure**	☐ **Respiratory**
☐ **Diabetes**	☐ **Kidney Disease**	☐ **Arthritis**
☐ **Vision problems**	☐ **Hearing problems**	☐ **TMJ/Dental**
☐ **Headaches**	☐ **Alcohol/Drug**	☐ **Emotional**

10. Have you ever had prior orthopedic injuries/problems or surgery for any body part?

NECK _____
BACK _____
ARMS _____
LEGS_____

11. Which of the normal activities are affected by your injury/surgery or pain?

_____
_____
_____

_____ _____

(SIGNATURE OF INSURED, AUTHORIZED, GUARANTOR) **(DATE)**