

## INITIAL EVALUATION – Sports Injury

LAST NAME:		FIRST NAME:		MI:		Date:	
What brings you into our office? 🔀 Sports Injury							
When did this a	accident happene	d?					
Immediately af	ter the accident,	did you feel dazed?	□ Yes		🗆 No		
Did you lose co	nsciousness?		□ Yes		🗆 No		
Was your head	injured?		□ Yes		🗆 No		
Immediately af	ter the accident,	did you experience:	🗆 Headache	□ Necł	k Paid	□ Low Back Pain	
Did you see and	other doctor befo	re coming here?	□ Yes		🗆 No		
Did you go to a	hospital after th	e accident?	🗆 Yes 🗆 No	$\Box$ Yes $\Box$ No If yes, which hospital?			
How did you ge	et to the hospital?	🗆 Ambulance	e 🗆 Drove self	🗆 Som	ebody e	else 🗆 Police	
Were any of the □ X-Ra	-	performed at the hos	pital? □ CT Scan		🗆 Lab	) Work	
Do you feel you	ur condition is:□	mproving	□ Staying th	e same	🗆 Get	ting Worse	
Have you lost t	ime from work?		□ Yes		□ No		
Can you perform	m physical work a	ctivities:	□ Yes		🗆 No		
lf no, b	ecause of:	🗆 Pain	Weakness		🗆 Stre	255	
Can you go to sleep without problems?			□ Yes		□ No		
Do you awaken because of pain?			□ Yes		□ No		
Did you have sleep problems before?			□ Yes	□ No			
<b>Activities of Daily Living</b> Please select all activities which you are currently experiencing problems:							
<ul> <li>Seeing</li> <li>Dressing</li> <li>Standing</li> </ul>	<ul> <li>Tasting</li> <li>Reading</li> <li>Leaning</li> </ul>		<ul> <li>Eating</li> <li>Writing</li> <li>Stooping</li> </ul>	<ul> <li>□ Hearing</li> <li>□Grasping</li> <li>□ Squatti</li> </ul>	g	<ul> <li>Insomnia</li> <li>Using the toilet</li> <li>Loss of Sexual Drive</li> </ul>	

Lifting

□ Exercising

Climbing

□ Reaching

Pushing

Pulling

□ Nervous

□ Reclining

Bending

🗆 Irritable

Bathing

□ Grooming

□ Sitting

Twisting

□ Pinching

Holding

□ Riding in car

Driving

Carrying

🗆 Air Travel

Kneeling

□ Sports

□ Restful sleeping

□ Tactile feeling

□ Loss of concentration

□ Changes in personality

Past Medical History	Please select all co	nditions that you have had	or are currently having:	
□None	□Other	□Abdominal pain	□Abnormal Weight gain/loss	□Angina
□Anorexia	□Anxiety	□Aortic aneurysm	□Arthritis	□Asthma
Bladder infection	□Blood disorder	□Brest lumps	Breast Soreness	□Bronchitis
□Cancer	□Cardiovascular	□Chest pain	□Chronic cough	□Chronic sinusitis
	disease/heart attack		-	
□Colitis	Constipation	Convulsions		Depression
Dermatitis	Diabetes	Difficulty swallowing	Dizziness	□Emphysema
Endometriosis	□Epilepsy	Excessive thirst	□Fainting	Frequent urination
□General fatigue	□Gout	□Hand pain	□Headache	Heart attack
□Heart disease	Heartburn/Indigestion	□Hepatitis	High Blood Pressure	□High cholesterol
□High PSA	High triglycerides	□Hypertension	□Irregular menstrual	□Irritable colon
□Jaw pain	Kidney disorders	Kidney stones	□Liver problems	Loss of appetite
□Loss of bladder	□Low back pain	Lung Disease	□Mental Disease	□Mid back pain
control				
■Muscular in coordination	□Neck pain	□Osteoarthritis	□Pain in ankle or foot	□Pain in lower leg or knew
□Pain in upper arm or elbow	Pain in upper leg and hip	□Painful urination	□PMS	□Pneumonia
Profuse menstrual flow	□Prostate problems	□Rapid heart beat	□Renal Disease	Theumatiod arthritis
□Scoliosis	□Shoulder pain	□Stroke	Swelling/stiffness of joints	□Thyroid disease
□Tinnitus	□Tuberculosis	□Tumor	□Ulcer	□Visual
(ear noices)				disturbances
□Wrist pain	□Gallbladder Problems			
Family History	Please select all conditions			
<u>Family History</u> □None	Please select all conditions a DOther	that run in your family: □Abdominal pain	□Abnormal Weight gain/loss	□Angina
□None □Anorexia	□Other □Anxiety	□Abdominal pain □Aortic aneurysm	gain/loss □Arthritis	□Asthma
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Surgical History	Please select all surgeries that you have had in the past.					
□ None	Other	<ul> <li>Abdominal Exploration</li> </ul>	Abdominoplasty	□ Abortion		
<ul> <li>ACL</li> <li>Reconstruction</li> </ul>	Adenoid Removal	□ Angioplasty	Appendectomy	<ul> <li>Bone Fracture Repair</li> </ul>		
<ul> <li>Breast Lump</li> <li>Removal</li> </ul>	Bunion Remova	<ul> <li>Carotid Artery Surgery</li> </ul>	Cataract Surgery	<ul> <li>Cervical spine</li> <li>Surgery</li> </ul>		
□Cholecystectomy	<ul> <li>Cosmetic Breast Burgery</li> </ul>	C-Section	Facelit	<ul> <li>Gallbladder</li> <li>Removal</li> </ul>		
Gastric Bypass	Heart Bypass Surgery	Heart Surgery	<ul> <li>Hemorrhoid</li> <li>Surgery</li> </ul>	Hernia Repair		
<ul> <li>Hip Joint Replacement</li> </ul>	Hysterectomy	<ul> <li>Kidney</li> <li>Transplant</li> </ul>	<ul> <li>Knee</li> <li>Arthroscopy</li> </ul>	<ul> <li>Knee Joint</li> <li>Replacement</li> </ul>		
□ Knee surgery	LASIK Eye Surgery	□ Liposuction	<ul> <li>Lumbar spine surgery</li> </ul>	Mastectomy		
<ul> <li>Prostate</li> <li>Removal</li> </ul>	Rotator Cuff Surgery	Vasectomy	TMJ Surgery	Tonsillectomy		
	<ul> <li>Surgical History was rev'd not contributory</li> </ul>					

**Medications** *Please select all medications that you are currently taking:* 

🗆 None	🗆 Other	🗆 Advil
🗆 Ambien	Analgesics	Anti-inflammatories
Aspirin	🗆 Atenolol	Blood Pressure Medication
Daily Vitamins	Diabetes Medication	🗆 Flexeril
Isorsubrine	🗆 Monopril	🗆 Motrin
Muscle relaxers	Pin Medication	🗆 Skelaxin
Synthroid	🗆 Tylenol	Vicodin

Allergies Please select all items that you are allergic to:

□ None	Other	□ Adhesive tape	🗆 Animal dande	□ Anticonvulsants
Barbiturates	Bee stings	🗆 Dirt	Dust mites	🗆 Eggs
□ Feathers	Felt tip pens	Fire ant stings	🗆 Fish	□ Gasoline fumes
🗆 Hair Spray	Histamine	Hornet stings	Insecticides	🗆 Insulin
□ lodine	🗆 Latex	🗆 Milk	🗆 Mold	□Nail polish remover
New Carpet	Newspaper ink	<ul> <li>Paint or paint thinner</li> </ul>	Peanuts	Penicillin
Perfume	Pets	🗆 Pollen	Pool Chlorine	Seafood
🗆 Shampoo	Shellfish	Smoke	🗆 Soy	🗆 Sulfa Drugs
Tobacco smoke		Wasp Stings	🗆 Wheat	□Yellow jacket stings
Social History Diago answer the following questions:				

**Social History** *Please answer the following questions:* 

$\Box$ Married	🗆 Single	$\Box$ Widowed	Divorced	$\Box$ Separated
			_	

Do you have any children? If yes, how many? \_\_\_\_\_

Do you use: 🗆 Tobacco 🗆 Alcohol 🗆 Coffee