SPORTS MEDICINE & PHYSICAL THERAPY

Phone: (401)-597-5665 **445 Saint Paul Street** **Fax: (401)-597-5667**
North Smithfield, RI 02896

Patient Name: _____ Date: _____
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
Sport: _____ Current School or Team:_____
School Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact Person: _____ Relation to Patient: _____
Emergency Contact #: _____
Primary Care Physician: _____ Email_____

MEDICAL HISTORY QUESTIONNAIRE: circle one. If yes, please elaborate.

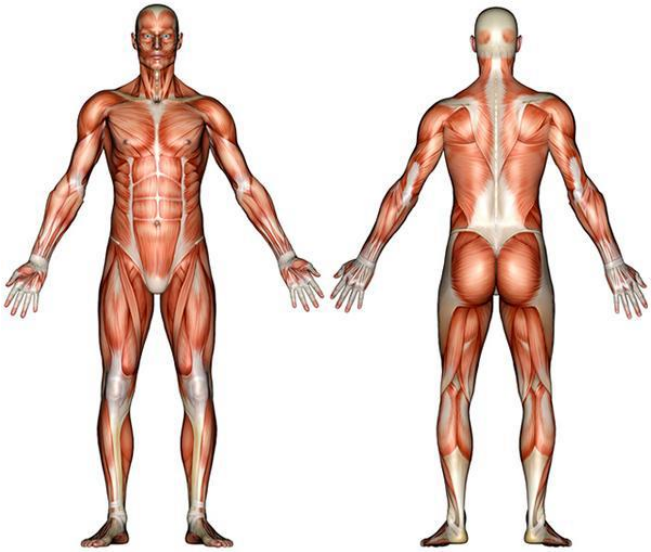
Yes No	Do you have high blood pressure?
Yes No	Do you smoke?
Yes No	Do you have any history of heart problems/surgery?
Yes No	Do you have a pacemaker?
Yes No	Do you experience chest pain with exertion?
Yes No	Do you have a problem with shortness of breath?
Yes No	Do you have asthma, bronchitis, or emphysema
Yes No	Do you have any allergies (please include allergies to latex)?
Yes No	Do you have a history of depression?
Yes No	Have you experienced night sweats or fever?
Yes No	Do you have pain at night that interrupts your sleep?
Yes No	Do you have any bowel and/or bladder problems?
Yes No	Do you have diabetes?
Yes No	Do you have a history of infectious disease?
Yes No	Do you have severe or frequent headaches?
Yes No	Do you have frequent joint sprains/muscle strains?
Yes No	Do you have a history of fractures?
Yes No	Have you ever had a head injury?
Yes No	Do you have a history of neck/back pain?
Yes No	Do you fatigue easily?
Yes No	Do you have any numbness or tingling?
Yes No	Do you have any weakness in your arms or legs?
Yes No	Do you have difficulty with balance or coordination?
Yes No	Do you experience dizziness or fainting?
Yes No	Do you have vision or hearing difficulty?

Do you currently have an injury impairment causing you pain?

If yes, Please rate your pain from 1-10 (1= no pain; 10 = the worst pain you have ever had)

1_____5_____10

Please Shade Symptomatic Areas:



Medications (please list all medications, dosage, and purpose)

_____

Surgeries/Dates

_____

Other Medical Problems (those not addressed in questionnaire)

_____

I believe all the information included in this form to be correct to the best of my knowledge.

Client Signature: _____Date:_____

What are your goals for this program and in your sport?