UND SCHOOL OF MEDICINE & HEALTH SCIENCES
UNIVERSITY OF NORTH DAKOTA

CENTER FOR SPORTS MEDICINE
2751 2ND AVE N, STOP 9013
GRAND FORKS, ND 58202-9013

Today's Date:_____

Name:_____ **Date of Birth:**_____

Cell/Home Phone:_____

Referring Physician:_____
Date of Injury:_____

Current injury/surgery and description of how the injury occurred:

Please check each of the following health care professionals you are currently seeking or have seen:

____ Medical Doctor
____ Osteopath
____ Dentist
____ Chiropractor
____ Other:_____
____ Physical Therapist
____ Occupational Therapist
____ Athletic Trainer
____ Psychiatrist/Psychologist

Please check if you've EVER been diagnosed with:

____ Cancer
____ Tuberculosis
____ Diabetes
____ Circulation Problems
____ Multiple Sclerosis
____ High Blood Pressure
____ Rheumatoid Arthritis
____ Epilepsy
____ Depression/Anxiety
____ Chemical Dependency
____ ADHD/ADD
____ Scoliosis
____ Other:_____
____ Thyroid problems
____ Heart Problems
____ Stroke
____ Anemia
____ Kidney Disease
____ Asthma
____ Other Arthritic
____ Emphysema
____ Mental Illness
____ Migraines
____ Hepatitis
____ Osteoporosis

Are you currently pregnant? Yes No
Do you have a pacemaker? Yes No
Do you have any metal implants? Yes No
Explain:_____
Do you have any allergies? Yes No
Explain:_____

Have you experienced any change in bowel/bladder habits? Yes No

Please list any other surgeries/injuries that have occurred in the last 5 years:

Please check any over the counter medications you've taken in the past week:

____ Aspirin
____ Advil/Motrin/Ibuprofen
____ Decongestants
____ Antihistamines
____ Other:_____
____Tylenol
____ Laxatives
____ Antacid
____ Vitamins

Please list current PRESCRIPTION medications:

Do you have any of the following symptoms?

____ Weight loss/gain
____ Nausea/Vomiting
____ Shortness of breath
____ Numbness/Tingling
____ Fatigue
____ Weakness
____ Fever/Chills/Sweats
____ Other:_____

Please indicate medical tests completed for the current problem:

Have you previously received physical therapy for the current problem? Yes No
Explain:_____

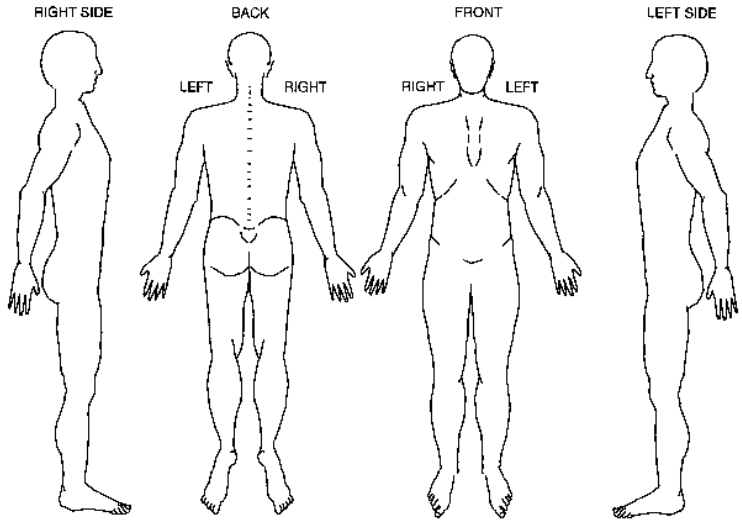
Please turn over and complete the back page……

On the following pain scale, please rate the pain you experiencing:

0	1	2	3	4	5	6	7	8	9	10

NO Pain **Mild** **Moderate** **Severe** **Extreme Pain**

Please shade affected area(s):



Please describe the pain you are experiencing:

Is your injury work related?	Yes	No
Have you missed work due to your injury?	Yes	No
Are you currently working?	Yes	No
Are you a student?	Yes	No
Do you live….	Alone	Family/ Friends

Please check the following activities that you CANNOT perform, or have pain/discomfort while performing:

____ Walking
____ Stairs
____ Sitting
____ Sleeping
____ In/Out of Bed
____ Driving
____ In/Out of Vehicle
____ Garbage Disposal
____ Combing Hair
____ Laundry
____ Cleaning
____ Cooking
____ Eating
____ Yard Work
____ Snow Removal
____ Dressing
____ Using the Bathroom
____ Showering
____ Sitting in Class
____ Studying
____ Writing
____ Other:_____

Please check any adaptive device(s) you may use:

____ Cane
____ Brace
____ Shoe lift
____ Walker
____ Crutches
____ Sling
____ Splint
____ Wheelchair
____ Other:_____

What are your goals for physical therapy?

Evaluation notes:

_____
Patient Signature (Parent/Guardian) Date

_____
Reviewed by Date