

+SportsPlus

Sports Medicine and Physical Therapy Center

Outpatient Screening Form

Please answer questions to the best of your ability.

Patient Name: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

Date of Injury: _____ **Please describe the injury:** _____

Please note any medical tests / procedures you have received as a result of this injury:
X-Ray MRI CT EMG Injection Other: _____

Have you had surgery as a result of this injury? YES NO If yes, when?

Please list any other surgeries:

Please list any current medications:

Please note any known allergies:

Please note any current or past medical conditions:

Bone / Joint Disease	Tendonitis / Bursitis	Broken / Fractured Bones	Arthritis
Spasms / Cramps	Sprains / Strains	Low back / Hip / Leg Pain	Neck / Shoulder / Arm Pain
Head Injuries	Jaw Pain / TMJ		
Diabetes	Seizures	Cancer / Tumors	Heart Disease
Kidney Problems	Asthma	High Blood Pressure	Pacemaker
Shortness of Breath	COPD	Fibromyalgia	Chronic Fatigue
Chronic Headaches			

Are or could you be pregnant?

Occupation: _____ **Job Duties:** _____

Are you currently working?

What is your goal for attending physical therapy?