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Athletics
SPORTS MEDICINE, LLC

CURRENT INJURIES

Date:

Name:

DOB:

ALLERGIES:

Occupation:

Tolerate Ibuprofen w/out stomach upset: *(circle)* YES NO

If you are a runner, how many miles have you put on your current running shoes?

(circle) *<100 200 300 >350*

□ Orthodontic Treatment *(circle)* YES NO

Date started _____ Date completed_____

☐ Jaw clicking/popping *(circle)* YES NO

☐ Limitation opening jaw *(circle)* YES NO

☐ Night Splint or retainer *(circle)* YES NO

☐ Do you wear...

☐ GLASSES ☐ CONTACTS

□ NEAR-SIGHTED ☐ FAR-SIGHTED

DATE	INJURY (Indicate right/left)	HOW INJURY OCCURRED	PROBLEMS RESULTING FROM INJURY
EXAMPLE 11/8/2009	*LOW BACK PAIN*	*TACKLED IN FOOTBALL GAME ON SATURDAY*	*CANNOT SIT WITHOUT PAIN. NUMBNESS IN MY RIGHT FOOT*

SPORTS ACTIVITY	# OF DAYS /WEEK	MILEAGE, YARDAGE OR HOURS PER WEEK	PRESEASON CONDITIONING	BIOMECHANICAL ASSESSMENT
EXAMPLE: CROSS COUNTRY	*6 DAYS*	*50 MILES PER WEEK*	*YES (6 WEEKS)*	*NEEDED*