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DANCER INTAKE AND MEDICAL HISTORY

Jame	Birth Date:	Age:	Male / Female				
roblem:	RL_	Onset Dat	e:				
ate of Surgery/Pending Surgery:	Procedure:						
ddress:	City	State	Zip				
mail address:							
ame of parent, spouse / significant other:							
ome Phone Work Phone	Cell						
rimary MD:	Referring MD:						
mployer / School Name and Phone:							
merg. Contact and Phone:							
	Dance School:						
working please describe:							
re you a Dance Student? Teacher?							
tyles of dance:							
ance is:Fun/RecreationalA go	oal for high school/college	Career path or o	current professiona				
ote how many hours you dance next to the da	ay: SWTW	TH	FS				
other sports, activities:							
			~~9				
ith 0 being no pain and 10 being the worst p	ain you could imagine. What does	your pain avera	ge:				
ease use key to demonstrate pain/symptoms			44				
(2,0)	Numbness		dles ^^^^				
	Burning xxxxxxxx Cold 00000000	Sharp/Stabb Achy)))))))					
		•	-++ (describe*)				
	Throbbing zzzzzzzz						
	Which of the following prov	voke or increase	your symptoms:				
	relevéplie	_ jump take off	jump landii				
	turnscambres	(back bends)	gestures (leg li				
	Other:						
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							

NAME:					· · · · · · · · · · · · · · · · · · ·
If your problem is at	a joint, do you experience:	popping	locking _	cracking _	snapping
What activities increa	ase your symptoms? ing Walking Drivi	ingKneeli	ng Twisting	Reaching	Bending
Rising Lifting	Stairs:going upgoing dow	nSquatting	g Other:		
Any symptoms other t	han pain that you may experienc	ce with the abo	ve checked activi	ities:	
What eases your sym	ptoms?				
HeatCold _	MedicationRestPo	sition Change	Other:		
Is your condition ove	rall: Improving	_Getting Worse	e Stayin	g the same	
Have you had any of	the following tests for this prob	olem?* 2	K-Ray MF	RIUltrasoun	d
	_Bone ScanEMGNerv se bring any reports, images, etc.				
	eatment for this problem in the	• • •	•	Describe:	
The you mu my ere	outment for this problem in the	puse:1 es			
Please circle any of the	he problems you have or have h	ad in the past:	<u> </u>		
Diabetes Chest Pain High Blood Pressure Heart Disease Heart Attack Heart Palpitations Pacemaker Headaches Sprains Do you menstruate? Explain briefly any cit	Bowel/Bladder Problems Urine Leakage Asthma/Breathing Problems Liver/Gallbladder Problems Fractures (broken bones) Hypoglycemia Special Diet Guidelines Rheumatoid Arthritis Broken Bones Y N Are your periods reg recled above and approximate data ciprofloxacin (Cipro), levofloxacin (International Control of Control	Any Allergie Osteoporosis Poor Cold To Other Allergi Hernia Seizures Metal Implan Dizziness/Fai Other: gular?Y tes of onset: Levaquin) or oth	s (penia) plerance es ats inting N Do you sn er medications end	ling in -cin or xin?	ities ds ng tion n the past?
	es of daily living and recreational lriving, dressing, house chores		are MOST limit ewhat Limited	ed by your condite Very Limited	ion Unable to Do
Daily Activity (i.e. 0	miving, dicasing, house chores) SUIII	CWHAL LIMILEU	very Limited	Chabic to Do
W-1-/D /G · /	/U.11:/E-4 C : 1 A ::	:4:			
work/Dance/Sports/	Hobbies/Extra Curricular Acti	vities			
Your goals to meet w	ith PT ⁹	<u> </u>		1	1
Signature				Data	
Signatule	(Patient or parent/guardian if m	ninor)		Date:	