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GYMNASTICS INTAKE AND MEDICAL HISTORY

Name_____ **Birth Date: _____ Age:_____ Male / Female**

Problem:_____ **R____ L_____ Onset Date:_____**

Date of Surgery/Pending Surgery:_____ **Procedure:**_____

Address:_____**City**_____**State_____ Zip_____**

Email address:_____

Name of parent, spouse / significant other:_____

Home Phone_____ **Work Phone**_____ **Cell**_____

Primary MD:___ **Referring MD:** _____

Employer / School Name and Phone: _____

Emerg. Contact and Phone:_____

REFERRED HERE BY: _____

Events: ___ Beam ___Bars ___Floor ___Pommel Horse ___ Rings ___Vault ___ Rhythmic Gymnastics

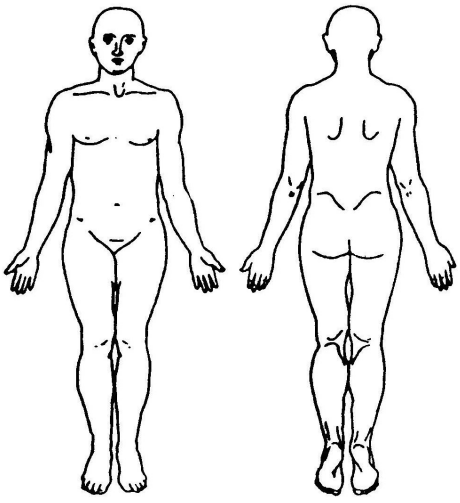
Training Gym/School: _____ **Current Training Level:** _____

Gymnastics is: ____Fun/Recreational Goal for: ____High School ____College ____Nationals ___Olympics

How many hours do you practice each day: S_____M_____ T_____ W_____ TH_____ F_____ S_____

Other sports/work activities: _____

Please use key to demonstrate pain/symptoms below:



Numbness ----------	Pins & Needles ^^^^^^^
Burning xxxxxxxx	Sharp/Stabbing /////////
Cold 00000000	Achy))))))))
Throbbing zzzzzzzz	Other ++++++ (describe*)

How limited are you at the gym?

___*Not at all* ___ *minimally* ___ *moderately* ___ *unable to participate*

Which of the following events provoke or increase your symptoms?

___ *Vault* ___ *Bars* ___*Beam* ___*Floor* ___*Rings* ___*Pommel Horse*

Which of the following skills provoke or increase your symptoms?

___*Back walkovers* ___*Front walkovers* ___ *Back handsprings* ___*Dismounts*

Other_____

NAME:_____

If your problem is at a joint, do you experience: ____**popping** ____**locking** ____**cracking** ____**snapping**

What activities increase your symptoms?
__ Standing __ Sitting __ Walking __ Driving __ Kneeling __ Twisting __ Reaching __ Bending

__Rising ___ Lifting Stairs: __going up __going down __Squatting Other:_____

Any symptoms other than pain that you may experience with the above checked activities:

_____

What eases your symptoms?

___Heat ___Cold ___Medication ___Rest ___Position Change Other:_____

Is your condition overall: ____ Improving ____Getting Worse ____ Staying the same

Have you had any of the following tests for this problem?* ___ X-Ray ____ MRI ___Ultrasound

____ CT Scan _____Bone Scan ___EMG ___Nerve Conduction Other:_____

If yes to above, please bring any reports, images, etc. to your first appointment

Have you had any treatment for this problem in the past? ___Yes ___No Please Describe:_____

_____

Please circle any of the problems you have or have had in the past:

Diabetes	Bowel/Bladder Problems	Any Allergies	Kidney Problems
Chest Pain	Urine Leakage	Osteoporosis(penia)	Eating Disorders
High Blood Pressure	Asthma/Breathing Problems	Poor Cold Tolerance	Cancer
Heart Disease	Liver/Gallbladder Problems	Other Allergies	Surgeries
Heart Attack	Fractures (broken bones)	Hernia	Skin Abnormalities
Heart Palpitations	Hypoglycemia	Seizures	Irregular periods
Pacemaker	Special Diet Guidelines	Metal Implants	Nausea/Vomiting
Headaches	Rheumatoid Arthritis	Dizziness/Fainting	Sexual Dysfunction
Sprains	Broken Bones	Other: _____	

Do you menstruate? __Y __ N Are your periods regular? __Y __N Do you smoke now? ____ In the past? ____

Explain briefly any circled above and approximate dates of onset: _____

Have you ever taken: ciprofloxacin (Cipro), levofloxacin (Levaquin) or other medications ending in -cin or xin? Y N

Please list (or provide list of) current medications: _____

_____

Please list the activities of daily living and recreational activities that are MOST limited by your condition

Daily Activity (i.e. driving, dressing, house chores)	**Somewhat Limited**	**Very Limited**	**Unable to Do**
Work/Dance/Sports/Hobbies/Extra Curricular Activities			

Your goals to meet with PT?_____

Signature_____ **Date:**_____

(Patient or parent/guardian if minor)