

DANCER 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: _____ Dance School: _____

If working please describe: _____

Are you a Dance Student? _____ Teacher? _____ Performer? _____ # Years Dancing? _____

Styles of dance: _____ Pointe: Y N Pre-Pointe: Y N

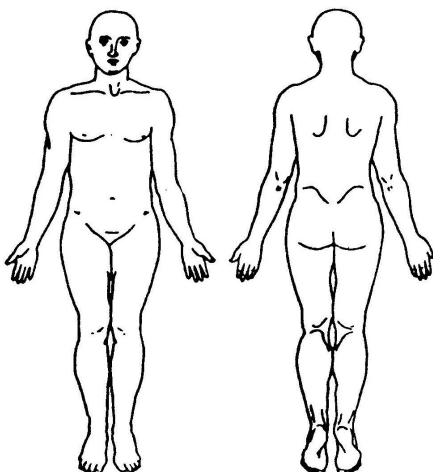
Dance is: ___ Fun/Recreational ___ A goal for high school/college ___ Career path or current professional

Note how many hours you dance next to the day: S ___ M ___ T ___ W ___ TH ___ F ___ S ___

Other sports, activities: _____

With 0 being no pain and 10 being the worst pain you could imagine. What does your pain average? _____

Please use key to demonstrate pain/symptoms below:



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

Which of the following provoke or increase your symptoms:

___ relevé ___ plie ___ jump take off ___ jump landing

___ turns ___ cambres (back bends) ___ gestures (leg lift)

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 _____

(Patient or parent/guardian if minor)

Date: _____