COASTherapy
PHYSICAL THERAPY
SPORTS MEDICINE GROUP

**NAME:**_____

**Age?** _____ **Today's Date:**_____

**Date of Injury/Surgery:** _____

**Dominant Arm?** Right / Left

**Height:** _____ **Weight:** _____

**Problem(s)** (please check all that apply)

† □ Pain?

□ Weakness?

† □ Instability / Dislocation

† □ Stiffness?

† □ Swelling?

† Other_____

**How did you injure yourself?**

† □ No injury – just started hurting

† □ Sports (which sport?)_____

† □ Motor Vehicle Accident

† □ Work / Job

Is there a Worker's Comp Claim?

Yes / No

**Sports Level:**

none / recreational / college / professional

**How long have you had symptoms?**

____Days _____ Months _____Years

**Please briefly describe the injury:**

_____

_____

**Diagnosis (if you have been told)?**

_____

**Medications (please List):**

_____

_____

_____

_____

**Have you experienced a fall in the Last Year? Please Explain:**

_____

_____

**Previous Treatments (other than surgery)** (medications, physical therapy, injections, bracing)

_____

_____

_____

**Previous surgery or Medical Conditions:** (include dates)

_____

_____

_____

**What makes your problem better?**

_____

**What makes your problem worse?**

_____

**Please describe your current limitations**

_____

_____

**Have you had any imaging studies?**

X-rays No / Yes Date: _____

MRI No / Yes Date: _____

CT Scan No / Yes Date: _____

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21501 Brookhurst Street, Suite E ● Phone: 714-963-7712 ● Fax: 714-965-0682
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**Allergies to medication(s)/Latex?** _____

**Do any diseases run in your family?** _____

**Medical History: (please circle)**

Do / did you have heart problems? No / Yes

Do / did you have ulcers / gastritis? No / Yes

Do / did you have diabetes? No / Yes

Do / did you have liver issues, hepatitis No / Yes

Do / did you have kidney disease? No / Yes

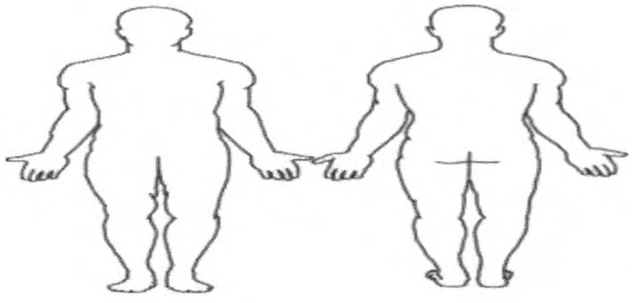
Do / did you have blood clots? No / Yes

Do / did you have cancer? No / Yes

Do / did you have HIV/Aids? No / Yes

Other? (Please use back of sheet if necessary) _____

Please circle area of discomfort on Body below:



| RATE THE INTENSITY OF YOUR PAIN | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AT BEST | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| AT WORST | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| CONSTANTLY | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

On the scale below **CIRCLE** your pain level in the past couple of days:


How optimistic are you that you'll get better? (Please Circle One)

Not at all Mildly Optimistic Fairly Very Optimistic Extremely

Goals for PT: _____

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