Back To Athletics - Liberty Hospital Sports Medicine

Athlete Name:_____ Date of Birth_____ Today's Date:_____

Referring Clinician:_____ Date of Injury:_____ Return to Doctor:_____

Description of Injury or injury diagnosis:_____

_____

How were you injured?_____

_____

_____

Description of past medical treatment for this injury:_____

_____

_____

Have you had surgery for this injury? Y or N. Date:_____ Doctor:_____

Do you have any restrictions with this injury? (Please explain)_____

_____

Current Activity Levels: (please circle)

In season or Out of season? Are you able to practice? Yes or No. Are you able to play in games Yes or No.

Are you currently involved in: Club Sports Parks and Recreation Sports School Sponsored Sports Other_____

School or Team Name:_____

Coaches Contact information:_____

Medical History:

Please list any past surgeries or medical procedures you have had in the last 18 months. Please include any injections, epidurals, and sutures. Please list the date of the surgery or medical procedure.

_____

_____

_____

_____

Please list any allergies, medications, or medical conditions:

_____

_____

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Orthopedic History Have you ever had an:	**Response**	**Comments:** *If answered is yes, give dates and explanation. Please include how long you were out of sports for each injury.*
Injury to shoulder(s)? ❑R ❑L	☐Yes ☐No	
Injury to elbow(s)? ❑R ❑L	☐Yes ☐No	
Injury to wrist/hand(s)? ❑R ❑L	☐Yes ☐No	
Injury to neck, back, or spine?	☐Yes ☐No	
Injury to ankle(s)? ❑R ❑L	☐Yes ☐No	
Injury to chest/ribs? ❑R ❑L	☐Yes ☐No	
Injury to hip(s)/pelvis? ❑R ❑L	☐Yes ☐No	
Injury to knee(s)? ❑R ❑L	☐Yes ☐No	
Injury to eye(s)? ❑R ❑L	☐Yes ☐No	
Shin Splints? ❑R ❑L	☐Yes ☐No	
Stress fractures?	☐Yes ☐No	Where:
Do you wear orthotics?	☐Yes ☐No	
Fractured a bone or dislocated a joint?	☐Yes ☐No	Where:
Ever had a sprain or strain that caused you to miss activity?	☐Yes ☐No	
Ever have an injury to bone or joint that needed an x-ray or MRI?	☐Yes ☐No	
Ever have an injury that needed rehabilitation, injection, or surgery?	☐Yes ☐No	
Diagnosed with a heart condition?	☐Yes ☐No	
Significant Weight loss?	☐Yes ☐No	Amount lost: Length of time:
Significant weight gain?	☐Yes ☐No	Amount gained: Length of time:
Wear any special equipment?	☐Yes ☐No	What type:
Wear any type of brace?	☐Yes ☐No	
Any pins, plates or screws from previous surgery	☐Yes ☐No	
An unhealed injury?	☐Yes ☐No	What is the injury: Occurred:

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Contact information

Parent/Guardian name:_____

Best contact phone number:_____

Best time to contact you?_____

Athlete Name:_____

Best contact phone number:_____

Best time to contact you?_____

Emergency Contact:_____

Relationship to athlete:_____

Best phone number to reach them at:_____

Alternative phone number:_____
