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|  | | | | | | **The University of West Alabama Athletic Training & Sports Medicine Center** revised 01/04/22 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s Date: | | | | | |  | | | | | | | | | | | | | Name: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | |  | | | | | | LAST | | | | | | | | | | | | | | | | | | | | FIRST | | | | | | | | | | | | | | M.I. | | | | |
| UWA Student # | | |  | | | | | | | | SSN Last 4: | | | | |  | | | | | | | | | | | Race: | | | | |  | | | | | | | | | Sex: | | | | M | | | | F | | | Date  of Birth: | | | | | |  | | | | | | | | | | Age: |  |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | STREET | | | | | | | | | | | | | | | | | | BOX#, ETC. | | | | | | | | | | | | | | | CITY | | | | | | | | | | | | | | | | | | STATE | | | | | | | | | ZIP CODE | | | | | | |
| Home Phone: | |  | | | | | | | | | | | | | | | Work Phone: | | | | | | |  | | | | | | | | | | | | | | | | Parent Cell Phone: | | | | | | | |  | | | | | | | | | | | | | Patient Cell Phone: | | | | | |  | | |
| Fax Number: | | | |  | | | | | | | | | | | | | | | | | | E-mail(s): | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent’s Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | School: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coach: | |  | | | | | | | | | | | | | | | | | | Sport: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Position: | | | | | | |  | | | | | | | | | | |
| Have you ever been a patient at the UWA Athletic Training & Sports Medicine Center before? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | or | | No | | | | | |
| If yes, please list condition(s) and approximate date(s): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Is this a recheck of a previous injury? | | | | | | | | | | | | | | | | | | Yes | | | | | | | | or | | | | No | | | | If yes, which one? | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| What body part is injured today? | | | | | | | | | | | | | | | Right | | | | | | | | or | | | | | Left | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you been seen by a physician or medical professional for this injury? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | or | | | No | | | | | If yes, please give the physician or | | | | | | | | | | | |
| medical professional’s name, where and when you saw them, and any recommendations that they gave you about this injury: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* PLEASE DO NOT WRITE BELOW THIS LINE \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HISTORY:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chief complaint: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Previous injuries or problems: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| Other symptoms/sensations: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Onset: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Mechanism of Injury: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Treatment to date: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Test or x-ray results: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
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| Description of pain: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Physician diagnosis & recommendations: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| Activities that aggravate pain: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Activities that relieve pain: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Other: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| Activities affected by injury: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Did they continue to play/practice/work: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **EVALUATION:** | | | | | | | | | | | | | | | | | | | | |  |
| Observation: | | | | | | |  | | | | | | | | | | | | | |  |
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| Palpation: | | | | |  | | | | | | | | | | | | | | | |  |
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| ROM (passive, active, active assisted): | | | | | | | | | | | | | | | | |  | | | |  |
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| Muscle testing: | | | | | | | | |  | | | | | | | | | | | |  |
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| Neurovascular: | | | | | | | | |  | | | | | | | | | | | |  |
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| Special Tests: | | | | | | | | |  | | | | | | | | | | | |  |
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| Measurements: | | | | | | | | |  | | | | | | | | | | | |  |
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| X-Rays or MSK US: | | | | | | | | | | | |  | | | | | | | | |  |
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| Other: | |  | | | | | | | | | | | | | | | | | | |  |
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| **ASSESSMENT:** | | | | | | | | | | | | | | | | | | | | | |
| Clinical Impression: | | | | | | | | | | | | |  | | | | | | | | |
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| **PLAN:** | | | | | | | | | | | | | | | | | | | | | |
| Goals: | | |  | | | | | | | | | | | | | | | | | | |
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| Treatment: | | | | | |  | | | | | | | | | | | | | | | |
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| Rehabilitation: | | | | | | | |  | | | | | | | | | | | | | |
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| Protective/Supportive devices: | | | | | | | | | | | | | | | |  | | | | | |
| Referral: | | | |  | | | | | | | | | | | | | | | | | |
| Other comments: | | | | | | | | | |  | | | | | | | | | | | |
| To Return to AT&SMC: | | | | | | | | | | | | | | |  | | | | | | |
| Activity Limitations: | | | | | | | | | | | | | |  | | | | | | | |
| Return to Activity: | | | | | | | | | | |  | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | Staff Signature: | |  | |