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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): |  |
|  |
| 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: |  |
|  |  |  |
| Other symptoms/sensations: |  |  |  |
|  |  Previous surgeries: |  |
| Onset: |  |  |  |
|  |  |  |
| Mechanism of Injury: |  |  Treatment to date: |  |
|  |  |  |
|  |  |  |
|  |  Test or x-ray results: |  |
|  |  |  |
| Description of pain: |  |  Physician diagnosis & recommendations: |  |
|  |  |  |
| Activities that aggravate pain: |  |  |  |
|  |  |  |
| Activities that relieve pain: |  |  Other: |  |
|  |  |  |
| 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: |  |  |
|  |  |  |
|  |  |  |
| 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: |  |  |
|  |  |  |
| Other: |  |  |
|  |  |  |
|  |  |  |
| **ASSESSMENT:** |
| Clinical Impression: |  |
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| **PLAN:** |
| Goals: |  |
|  |  |
| Treatment: |  |
|  |  |
| Rehabilitation: |  |
|  |  |
| Protective/Supportive devices: |  |
| Referral: |  |
| Other comments: |  |
| To Return to AT&SMC: |  |
| Activity Limitations: |  |
| Return to Activity: |  |
|  |
|  | Examined by: |  |
|  |  |
|  | Staff Signature: |  |