UCSF Benioff Children's Hospital Oakland

SPORTS MEDICINE CENTER FOR YOUNG ATHLETES

www.childrenshospitaloakland.org

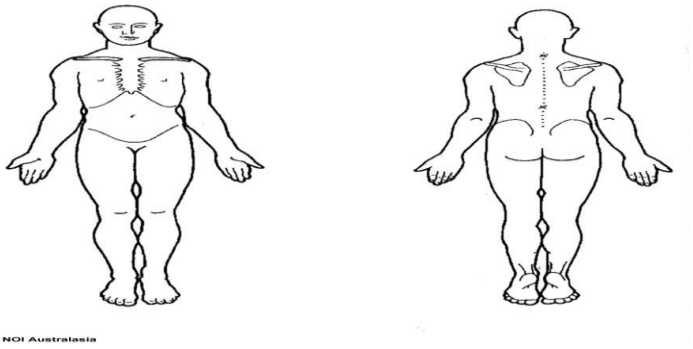
Patient Health and Sport Questionnaire

Name of Patient/Athlete:_____ Age: _____ MR: _____
School:_____ Grade: _____ DOB: _____
Sports/Teams: _____
Coaches Names/Contact Info:_____
How did you hear about our clinic? Check all that apply:
___ Physician ___ NCS event ___ School Athletic Trainer ___ Media/TV ___ Other:_____

Date of injury:_____ Date of surgery:_____
Please describe your injury: _____
_____
_____
Regarding this injury, have you had an:
____ X-RAY ____ MRI ____ CT Scan ____ EMG
If yes, what are the results? _____
_____
What treatment have you done for this injury previously (if any)?
_____
_____
How has this injury limited your sport/activity? _____
_____

Please mark where you feel your pain/symptoms and describe them: (circle all that apply)

Constant (always present) / Intermittent (comes and goes)
Sharp / Achy / Dull
Numb/Tingling /Shooting / Burning



Do you currently have, or have had in the past, any of the following conditions?
___ yes ___ no Diabetes
___ yes ___ no Unexplained weight loss
___ yes ___ no Bowel / Bladder
___ yes ___ no Seizures
___ yes ___ no Hernia
___ yes ___ no Rheumatoid arthritis
___ yes ___ no Allergies _____
___ yes ___ no Dietary concerns _____
___ yes ___ no Asthma _____
___ yes ___ no Previous Surgery _____
___ yes ___ no Immunizations up to date
___ yes ___ no Barriers to learning or communication
** If yes, explain: _____

Additional comments (medical or general health issues?):
_____
_____
Please list all medications you are currently taking:
_____

Please circle the number that best describes your pain:

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORSE POSSIBLE)

What makes your pain / symptoms better? _____
_____

What makes your pain / symptoms worse? _____
_____

What would you like to achieve with your rehabilitation program (sport goals, pain control, etc.)?
_____

Are you interested in a post-rehabilitation / sport specific training and conditioning program? Y / N

Email:_____

Thank you for filling out this form. This will assist us in providing you with comprehensive care for your present injury.

Signature: _____ Date: _____

Signature of **parent / guardian** (if patient is under 18): _____ Date: _____

Office use only:
Clinician has reviewed and discussed with patient/caregiver: _____ Date: _____

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(Trial Form)