Injury Evaluation Form

Patient to complete *shaded* area only. Please print legibly.

Patient Information

Patient Name: _____ Student ID: _____ Grad. Yr: _____

Sport/Activity: _____ School: _____

Parent/Guardian(s) Name(s):_____

Home Address: _____

City: _____ Zip Code: _____ Home Phone: (____)_____

Student Cell: (____)_____ Parent Cell: (____)_____

Patient Injury/Illness History

1. Have you been into our athletic training room for a previous injury evaluation? No Yes
2. Have you had this injury/illness before? No Yes When? _____
3. Where is your pain/discomfort? _____
4. How long have you felt your pain/discomfort? _____
5. What activities *increase* your pain/discomfort? _____
6. What can/have you done to *relieve/treat* this injury/illness? _____
7. Have you seen a physician (MD) for this injury/illness? No Yes, When? _____
8. Do you have any allergies? No Yes, List_____
9. Please list prescription/over-the-counter medicines you take regularly: _____

_____

Orthopedic Evaluation Summary

Area(s) of body involved:

Head	Ears	Elbow	Spine
Face	Nose	Lower Arm	Back
Eye(s)	Neck	Wrist	Hip
Mouth	Shoulder	Hand	Buttock
Teeth	Upper Arm	Finger	_____
Knee	Thigh	Ankle	_____
Toe	Foot	Lower Leg	_____

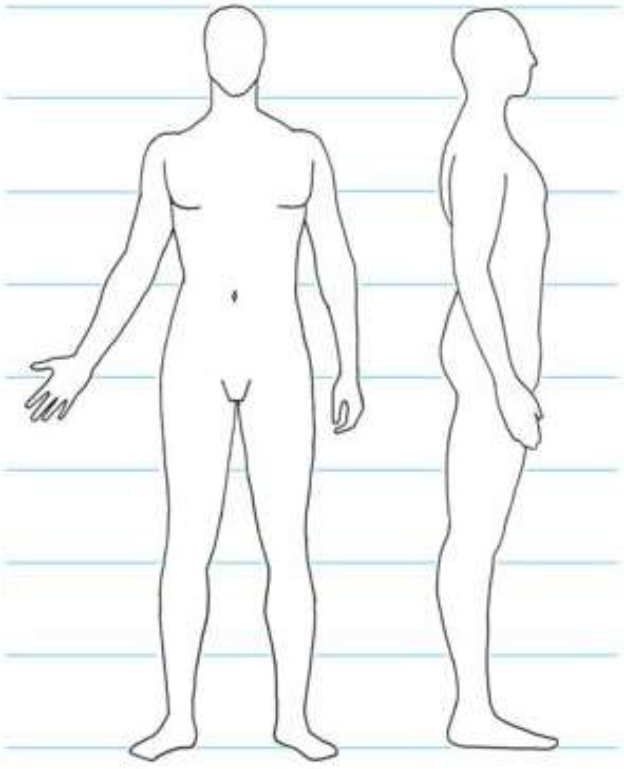
Location(s) of pain/discomfort:

Left	Proximal	Superficial	_____
Right	Distal	Deep	_____
Medial	Superior	Anterior	_____
Lateral	Inferior	Posterior	_____

Type of Injury:

Strain	Blister	Hematoma	Tenosynovitis
Sprain	Fracture	Spasm	Cramp
Contusion	Stress Fx	Avulsion	Ingrown Toenail
Laceration	Tendonitis	Burn	Neuroma
Abrasion	Fasciitis	Dislocation	_____
Puncture	Concussion	Bursitis	_____

Denote specific location of injury on diagram.



Patient Evaluation Notes

Subjective Report

Objective Report

Assessment

Plan/Treatment

Evaluator's Printed Name

Evaluator's Signature

Date