DOB______________

INITIAL EVALUATION

Subjective:

Name:____Date____________________Age:______________
Physician:______________________________Diagnosis:____
Occupation:_____________________________Sport/Activity:_____________________________________
Physical Demands of the job?____

Please circle which body part you are seeking treatment: Left Right
Neck Mid Back Low Back Shoulder Elbow Hand/Wrist Hip Knee Ankle/foot
Other____

Date of injury:_____________ Date of Surgery:____________

What caused your injury or problem?____
____

What is your chief complaint?____

Have you had similar occurrences in the past?____
____

Have you had previous treatment? What kind?__________________________________ When:_________

Circle recent tests- MRI Xrays CT Scan Bone Scan EMG Other______________________________

Medical History (Circle) High Blood Pressure, Diabetes, Arthritis, Osteoporosis/penia, Cancer**,** Allergies, Heart condition, Pace Maker, Stroke, Pregnancy, cortisone injections
Other including orthopedic conditions and surgeries:____
____
____
____

Current Medications-____
____

Pain rating: Indicate your <u>usual</u> level of pain by circling the appropriate number on the scale:

0____1____2____3____4____5____6____7____8____9____10 **Worst Pain=________ Least Pain=________**
mild moderate extreme agony

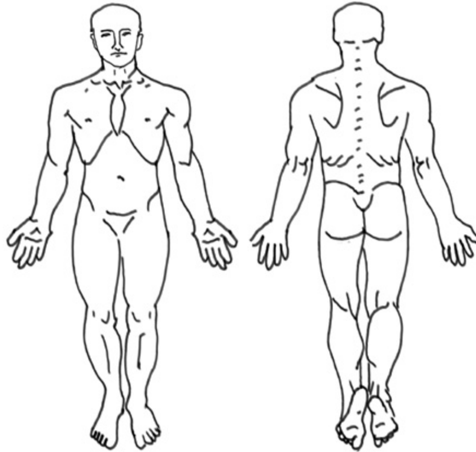
Does your pain?(circle) Throb Burn Stab Ache Other____

Is your pain constant? Yes No

TURN PAGE OVER

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins and Needles	Burning	Stabbing	Aching
===	○○○	xxx	///	***



Does your pain radiate? Yes, where___________________________________ No

Numbness, tingling, or weakness? Yes, where______________________________________ No

What makes your pain worse? ____

____

What makes your pain better?____

____

What is your goal for your treatment?____

What activity would you like to resume?____

How long has it been since you have been able to perform this activity? ________________________________

When is your next Dr. appt.?__________________

Email (for receipt purposes only):____

Patient Signature:______________________________ Date:________________________

FOR THERAPIST USE ONLY
COMMENTS:
Initial Evaluation:____

____

____

____

____

____

Therapist Signature____Date______________________

CONSENT FOR CARE AND TREATMENT

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Towson Sports Medicine to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and/or mental condition.

HIPAA

I, the undersigned, have been made aware of my rights as a patient under the "Health and Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

MISSED APPOINTMENTS

Towson Sports Medicine requires that you give us **24 hours** notice of cancellations. If 24 hour advanced notice is not given, you may receive a **$25.00** missed appointment fee. Please contact **410-337-8847** to cancel appointments. This policy does not apply in situations of extreme weather. We also ask that you bring your appointment slip to each appointment.

Thank You!

I have read and understand the statements noted above.

Patient/Guardian/Responsible Party_____________________________ Date________

Please Print Your Name_______________________________________ Date________

Towson Sports Medicine Representative_________________________ Date________