THE POLYCLINIC

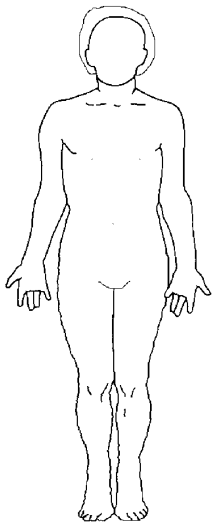
Sports Performance & Medicine Intake Form

Name _____ Age _____ Date _____ MRN _____

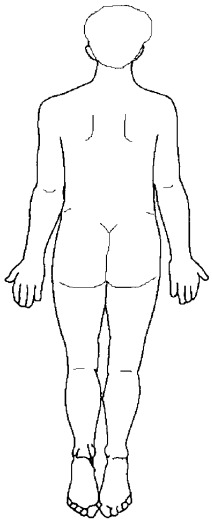
Pain Diagram: Mark the areas on your body where you now feel your typical pain. Include all areas. Use the following symbols (if you have not pain, skip to the next page):

Pain XXXXX Numbness OOOOO Pins and Needles /////

Put a large X where you have the most pain



Front



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PLEASE CIRCLE ALL THAT APPLY:

How long have you had your pain? ___Weeks ___Months ___Years

How often do you have your pain? Constant Comes and goes

What caused the onset of pain? Work Auto accident Lifting Twisting
Other _____ Unknown

Pain Progression? Better Worse Unchanged

Quality of pain? Stabbing Shooting Aching Burning Cramping
Dull None Other _____

How severe is your pain at worse? **1 2 3 4 5 6 7 8 9 10**
(0=no pain, 10=worst pain imaginable)

How severe is your pain at best? **1 2 3 4 5 6 7 8 9 10**

What makes the pain worse? _____

What makes the pain better? _____

Have you had any of the following? MRI CT scan Bone scan X-rays
Nerve Testing None Other _____
Massage PT Chiropractor Acupuncture
Medication None Other _____
Consult with a medical/surgical specialist _____

EXERCISE

Number of days per week? _____

Number of minutes on average? 5 10 15 20 >30

Do you sweat while exercising? Yes No

REVIEW OF SYSTEMS. Mark any of the following symptoms that you have had during the past year.

CONSTITUTIONAL SYMPTOMS
___Recent weight change
___Fever or chills
___Night sweats
___Lack of energy or fatigue
___none of the above

EYES
___Eye pain or redness
___Loss of vision
___Blurred vision or double vision
___none of the above

EARS/NOSE/MOUTH/THROAT
___Hearing loss
___Ringing in ears
___Nose bleeds
___Difficulty swallowing
___Hoarseness
___none of the above

CARDIOVASCULAR
___Chest pain
___Abnormal heartbeat
___Shortness of breath with activity
___Shortness of breath when lying flat
___Swelling of feet or ankles
___none of the above

RESPIRATORY
___Chronic or frequent coughs
___Coughing up blood
___Breathing problems
___none of the above

GENITOURINARY
___Bloody urine
___Urgency of urination
___Frequency of urination
___Painful or difficult urination
___Dribbling or incontinence of urine
___Numbness over groin, genitalia or buttocks
___Sexual difficulties
___none of the above

MUSCULOSKELETAL
___Joint pain, stiffness, or swelling
___Muscle pain or cramps
___Increased pain with laying flat
___none of the above

SKIN/BREAST
___Rash
___Skin sores or ulcers
___Breast pain, lump or discharge
___none of the above

STOMACH AND INTESTINES
___Frequent nausea or vomiting
___Bloody vomiting
___Abdominal pain
___Recurring diarrhea
___Blood in stools
___Frequent or severe constipation
___none of the above

NEUROLOGICAL
___Headaches
___Light headedness or dizziness
___Convulsions or seizures
___Numbness or tingling in arms or legs
___Weakness in arms or legs
___Frequent falls
___none of the above

PSYCHIATRIC
___Difficulty sleeping
___Loss of appetite
___Memory loss or confusion
___Nervousness or anxiety
___Stress
___Depression
___none of the above

ENDOCRINE
___Easy bleeding or bruising
___Swollen glands or lumps in neck, armpits or groin
___none of the above

ALLERGIC/IMMUNOLOGIC
History of allergic reaction to:
___Penicillin or other antibiotics
___Morphine, Demerol, or other narcotics
___Vaccines or anesthetics
___none of the above

OTHER (please list any other symptoms)

_____
_____
_____