BOSTON SPORTS & BIOLOGICS

INJURY INFORMATION FORM

Name:_____ Today Date: _____

□ Right-Handed □ Left-Handed

Have you had a fall in the past year □ Yes □ No
Did the fall result in an injury? □ Yes □ No
Are you Pregnant? □ Yes □ No

BACKGROUND

- Occupation: _____
- Sports/Exercise Activities: _____
- (Student Athletes) High school/College or organization: _____

REASON FOR VISIT

- Did you have an injury? □ Yes □ No If yes, what was the date of injury?_____
  - If this is a work-related injury, is it under workers compensation? □ Yes □ No
    - Have you missed work because of this problem? □ Yes □ No
- Brief history of what is bothering you, what body part is injured, and how it happened:

_____
_____
_____

- Please indicate whether you have had any of the following studies and write when/where the most recent was:

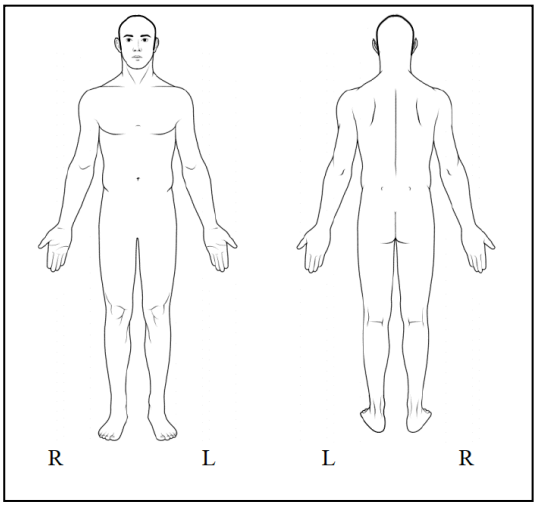
	Yes	No	Provide details of imaging study (body part, when/where study performed)
X-ray	□	□	_____
CT Scan	□	□	_____
EMG	□	□	_____
Bone Scan	□	□	_____
MRI	□	□	_____
Other Imaging Study	□	□	_____

- Have you seen another doctor for this? □ Yes □ No If yes please describe? _____
- Have you had Surgery for this before? □ Yes □ No If yes please describe? _____

LOCATION OF PAIN

- When do you have pain?
  - □ Constant □ Intermittent/Occasional
  - □ During/After activities □ At night
- What activities provoke pain?
  - Describe:_____
- Does the pain limit your activity?
  - Describe:_____

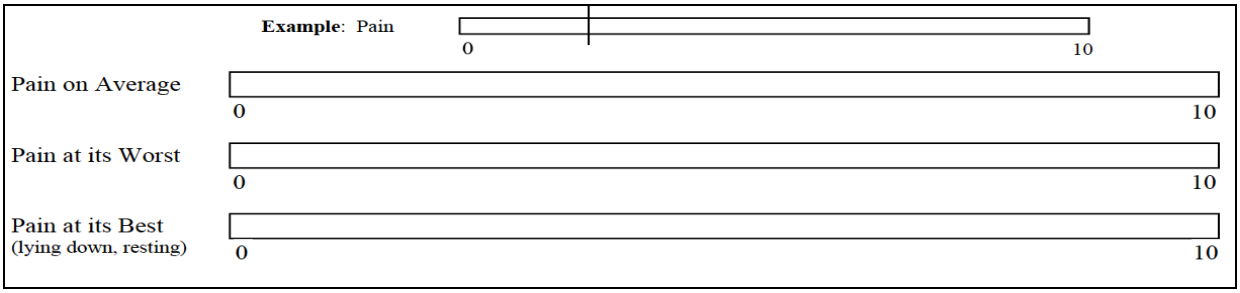
**Mark the areas on your body where you feel symptoms. Please include all affected areas



- Describe your pain (check all that apply)
  □ Burning □ Numbness □ Tingling □ Dull
  □ Decreased sensation □ Sharp □ Shooting
  □ Stabbing □ Throbbing □ Aching
  Other Symptoms: _____

HOW SEVERE IS YOUR PAIN?

On a scale of 0-10 how bad is your pain? 0 = no pain 10 = worst pain you can imagine



- Have you tried of the following treatments (check all that apply):
  □ Physical therapy Location/Dates _____

- Of the following list of treatment, please indicate which you have tried and if they helped:

	Treatment	Which type	Helpful	No help
□	Anti-inflammatory Medications		□	□
	□ Ibuprofen	□ Advil		
	□ Celebrex	□ Naproxen/Aleve		
□	Muscle Relaxants		□	□
□	Narcotic Pain medications		□	□
□	Cortisone Injection	□ Date(s):	□	□
□	Physical Therapy	□ Date(s):	□	□
□	Chiropractor	□ Date(s):	□	□
□	Ice/ Hot Packs		□	□
□	Trigger Point Injection	□ Date(s):	□	□
□	Acupuncture	□ Date(s):	□	□
□	Shockwave Therapy	□ Date(s):	□	□
□	PRP/Orthobiologic Injection	□ Date(s):	□	□
□	Other:		□	□

Additional Notes/Information regarding treatments you've tried: _____

_____

Thank you for taking the time to complete this form

Patient's Signature:_____ Date: _____