PRO SPORTS Physical Therapy

Huntington
467 New York Avenue
Huntington, NY 11743
631.424.1100

Oyster Bay
9 East Main Street
Oyster Bay, NY 11771
516.864.2900

Locust Valley
11 Birch Hill Road
Locust Valley, NY 11560
516.801.6020

HEALTH/MEDICAL QUESTIONNAIRE

PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Address: _____ Apt:_____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Physician: _____ Phone:_____

How did you hear about us? _____

EMERGENCY/PARENT OR GUARDIAN CONTACT INFORMATION

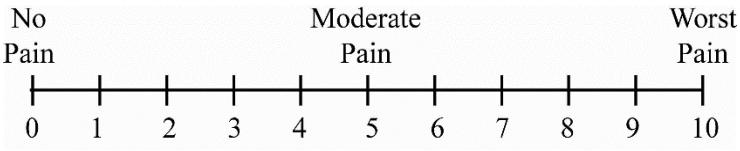
Name: _____ Relation to Patient: _____
Home Phone: _____ Cell Phone: _____
Email: _____

MEDICAL HISTORY

Injury or complaint being treated for today: _____
_____

How did the injury occur: _____
_____

Current Pain Level:



Current Medications:
_____
_____

Allergies:
_____
_____

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Have you had or do you presently have any of the following conditions? (Select all that apply.)

- O Heart Attack
- O Angina
- O Abnormal EKG
- O Heart Medications
- O Valve Disease
- O Aneurysm
- O Embolism
- O Fainting/Dizziness
- O Unusual Fatigue
- O Head/Neck Injury
- O Arm/Elbow Injury
- O Ankle/Foot Injury
- O Bone Fracture
- O Recent Surgery: _____
- O Thrombophlebitis
- O Asthma
- O Pacemaker
- O Heart Murmur
- O Respiratory Infections
- O Irregular Heartbeat
- O Rapid Heartbeat
- O High Cholesterol
- O Arthritis
- O Hip/Pelvis Injury
- O Shoulder/Clavicle Injury
- O Wrist/Hand Injury
- O Tennis Elbow
- O High Blood Pressure
- O Low Blood Pressure
- O Diabetes
- O Epilepsy/Seizures
- O Anemia
- O Lung Disease
- O Shortness of Breath
- O Chest Pains
- O Low Back Pain
- O Upper Back Injury
- O Knee/Thigh Injury
- O Nerve Damage
- O Osteoporosis
- O Other: _____

ACTIVITY HISTORY

Do you currently play a sport or participate in an athletic program? If so, which sports?

_____

Do you participate in a regular exercise program at this time? If so, is it with a trainer?

_____

Do you have any injuries that may interfere with exercising? If so, briefly describe:

_____

What are your personal health and fitness-related goals? (Select all that apply.)

- O Cardiovascular Fitness
- O Sport-Specific Training
  Sport:_____
- O General Fitness
- O Lower Cholesterol
- O Lower Blood Pressure
- O Injury Rehab
- O Lose Weight
- O Improve Flexibility
- O Increase Strength
- O Reduce Stress
- O Pain Management

I have answered the preceding questions to the best of my ability. I have understood all of the questions asked of me and have been given the opportunity to have any of my concerns clarified to my satisfaction. I further understand that thorough and honest responses to these questions are essential to my safety and prudent recommendations from the Pro Sports staff.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian Signature (For Patients Under 18) Date