HOSPITAL FOR SPECIAL SURGERY

Rehabilitation Department
Sports Rehabilitation and Performance Center

PERFORMANCE PROGRAM

CLIENT INTAKE FORM

Evaluator _____

Date _____

Name _____ SSN _____
Last First

Address _____
Street City State Zip

Phone No. _____ _____ _____
Home Work Cell

E-mail _____ What is your ***preferred*** contact? ❒ Home ❒ Work ❒ Cell ❒ E-mail

Emergency/Parental Contact _____
Name Relationship to Client Phone Number

Referred by _____

Date of Birth _____ Age _____ Sex: ❒ Male ❒ Female

Height _____ Weight _____ Ideal Weight _____ Resting BP _____/_____ Heart Rate _____

Occupation _____ ❒ Employed ❒ On disability ❒ Retired (year) _____
❒ Unemployed ❒ Student

HEALTH QUESTIONNAIRE (To be completed by parent or guardian if under 18)

FITNESS

Do you have any difficulty with physical exercise? ❒ NO ❒ YES

Have you received any advice from a doctor or physical therapist to limit exercise? ❒ NO ❒ YES

If yes, please explain _____

Please describe your current fitness program _____

_____

How long have you been on this fitness program? _____

If not currently on a fitness program, please describe any past programs _____

_____

How long were you on this program? _____

Why did you stop? _____

Please describe any activities/sports that you participate in (or have participated in) _____

_____

How long have/had you participated? _____

_____

Current or past injuries/health concerns _____

_____

Treating Doctor(s) _____

Treating Physical Therapist _____

What are your primary goals and objectives for the Sports Rehabilitation and Performance Center to assist you with?

_____

How soon do you expect to see results and outcomes? _____

How much time can you dedicate towards reaching your goals and objectives? _____

What workout facilities do you have access to? _____

Have you ever been denied athletic/physical fitness participation for medical reasons? ❒ NO ❒ YES

If yes, why? _____

GENERAL HEALTH

Please indicate if you or any members of your immediate family have or had any of the following illnesses or conditions. Include dates and explanations where needed.

	Self	Family		Self	Family
Absence of paired organ (i.e. eye, kidney)	❒	❒	History of Fainting or Dizziness	❒	❒
Allergies (if yes, list below)	❒	❒	Infectious disease (such as tuberculosis, hepatitis, mononucleosis)	❒	❒
Anemia (including sickle cell)	❒	❒	Increased blood cholesterol	❒	❒
Arthritis	❒	❒	Kidney/Genitourinary disorder	❒	❒
Asthma/Respiratory disorder	❒	❒	Low blood sugar (hypoglycemia)	❒	❒
Blood disorder	❒	❒	Lung problems	❒	❒
Broken bones/fractures	❒	❒	Multiple sclerosis	❒	❒
Cancer	❒	❒	Musculoskeletal disorders	❒	❒
Circulation/Vascular problems	❒	❒	Pregnancy	❒	❒
Depression	❒	❒	Psychological disorders	❒	❒
Developmental or growth problems	❒	❒	Osteoporosis/osteopenia	❒	❒
Diabetes/High blood sugar	❒	❒	Repeated infections	❒	❒
Epilepsy/Convulsive disorder	❒	❒	Rheumatologic disorders	❒	❒
Frequent/severe headaches	❒	❒	Skin diseases	❒	❒
Gastrointestinal/Stomach problems	❒	❒	Thyroid problems	❒	❒
Head injury/concussion (if yes, how many? ___)	❒	❒	Weight problem (overweight, underweight)	❒	❒
Heart problems	❒	❒	Other _____	❒	❒
Heat stroke/exhaustion	❒	❒	_____		
High blood pressure	❒	❒			

If **YES** to any of the above, please explain.

_____

_____

_____

Allergies _____

_____

Do you have any other type of illness, injury or condition that is being monitored by a doctor? ❒ NO ❒ YES

If yes, please explain _____

Within the past year, have you had any of the following symptoms?

❒ Bowel problems	❒ Dizziness or blackouts	❒ Joint pain or swelling	❒ Urinary problems
❒ Chest pains	❒ Fever/chills/sweats	❒ Loss of appetite	❒ Vision problems
❒ Coordination problems	❒ Headaches	❒ Loss of balance	❒ Weakness in arm or leg
❒ Cough	❒ Hearing problems	❒ Nausea	❒ Weight loss/gain
❒ Difficulty sleeping	❒ Heart palpitations	❒ Pain at night	❒ Other _____
❒ Difficulty walking	❒ Hoarseness	❒ Shortness of breath	_____

Please list any medications you are ***currently*** taking and the reason(s) for the medication:

_____

_____

_____

_____

Please list any medications you have taken ***in the past*** and the reason(s) for the medication:

_____

_____

_____

_____

Do you take any vitamins, minerals, supplements or other non-prescription medications? ❒ NO ❒ YES

If yes, please list _____

Have you ever been hospitalized? ❒ NO ❒ YES If yes, why? _____

Do you currently smoke? ❒ NO ❒ YES Have you smoked in the past? ❒ NO ❒ YES

Have you used any treatments to stop smoking? ❒ NO ❒ YES

Do you chew or use mouth based tobacco products? ❒ NO ❒ YES

Do you drink alcohol? ❒ NO ❒ YES If yes, how many drinks per week? _____

Do you maintain a healthy diet? ❒ NO ❒ YES

Do you regularly eat breakfast? ❒ NO ❒ YES Lunch? ❒ NO ❒ YES Dinner? ❒ NO ❒ YES

Have you/Are you experiencing excess fatigue or stress? ❒ NO ❒ YES

Do you have poor posture? ❒ NO ❒ YES Do you sit excessively? ❒ NO ❒ YES

MEDICAL TESTS

Have you had any of the following medical tests *within the past year*?

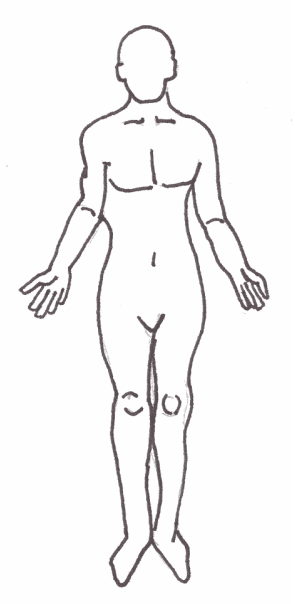
❒ Angiogram	❒ Echocardiogram	❒ Stress test
❒ Blood tests	❒ EKG (electrocardiogram)	❒ X-Rays
❒ CT Scan	❒ MRI	❒ Other _____

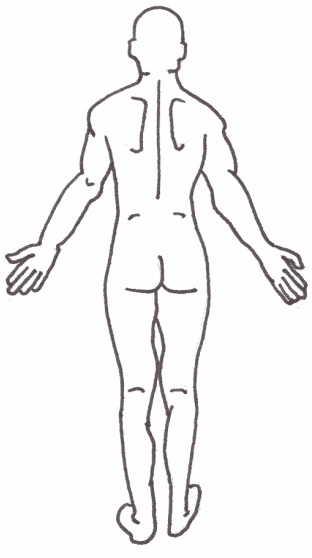
ORTHOPEDIC HISTORY

Please include any major **musculoskeletal injuries and/or surgeries** in the following areas. Please include sprains, strains, dislocations, fractures, arthritis, bursitis or tendonitis.

Area			Date	Injury Type	Outcome
Foot	❒ Right	❒ Left	_____	_____	_____
Ankle	❒ Right	❒ Left	_____	_____	_____
Lower Leg	❒ Right	❒ Left	_____	_____	_____
Knee	❒ Right	❒ Left	_____	_____	_____
Thigh	❒ Right	❒ Left	_____	_____	_____
Hip/Pelvis	❒ Right	❒ Left	_____	_____	_____
Spine			_____	_____	_____
Torso			_____	_____	_____
Shoulder	❒ Right	❒ Left	_____	_____	_____
Upper Arm	❒ Right	❒ Left	_____	_____	_____
Forearm	❒ Right	❒ Left	_____	_____	_____
Wrist	❒ Right	❒ Left	_____	_____	_____
Hand	❒ Right	❒ Left	_____	_____	_____
Neck			_____	_____	_____
Head			_____	_____	_____
Other	❒ Right	❒ Left	_____	_____	_____

BODY DIAGRAM





Do you understand that you are taking a risk whenever you undertake an exercise program? ❒ NO ❒ YES

I declare the above information on all four pages of this Client Intake Form is to be accurate, correct, and a true reflection of my (or my minor's) physical condition.

Signature _____ Date _____