Injury History

Name ___________________________________

Date ____________________________________

PREVIOUS INJURIES (include dates and treatments)

Foot / Ankle ____

Knee ____

Hip ____

Back ____

Shoulder ____

Neck ____

Wrist / Arm ____

Diagnostic Testing for above injury:

X-Ray CT Scan MRI EMG Bone Scan

Do you use any braces or supports? YES / NO

What for? ____

Hand Dominance? LEFT / RIGHT

Wear glasses or contacts during activity? YES / NO

Any known allergies ____

CURRENT MEDICATIONS ____

Please indicate any other surgeries or medical conditions not listed above:

Signature _______________________________________

Parent / Guardian (if under 18) ____

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