Banff Sport Medicine

Initial Consult
PATIENT HISTORY

Dr. M. Heard
Dr. G. Buchko
Dr. L. Hiemstra

PATIENT NAME: ____________________ Date__________

Symptoms / Injury Description

What are you being seen for today? ☐ Right ☐ Left ☐Both Body part __________

Did your problem come on gradually or as a result of an injury? ☐ Gradually Date of onset: __________

☐ Injury Date of injury: __________

Describe what happened: __________

____

The main problem is? ☐ Pain ☐ Instability ☐ Stiffness ☐ Weakness ☐ Other__________

Rate your injury during the last month (CIRCLE): (no problem) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Does your injury wake you up at night? ☐ Yes ☐ No

What, if anything, makes your injury worse? __________

What, if anything, makes your injury better? __________

Sports / Recreation

List your regular sports/recreation activities:

1. __________ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other__________
2. __________ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other__________

Previous Surgery / Treatments / Tests

Have you had a similar injury or a surgery in the past?:

RIGHT: Injuries? ☐ Yes ☐ No	**LEFT:** Injuries? ☐ Yes ☐ No
Describe:	Describe:
When?	When?
RIGHT: Surgeries? ☐ Yes ☐ No	**LEFT:** Surgeries? ☐ Yes ☐ No
Describe:	Describe:
When?	When?

What treatment(s) have you had for your injury? ☐ Nothing ☐ Physiotherapy ☐ Medication ☐ Injections

☐ Sling ☐ Surgery ☐ Other: __________

What tests have you had done for your injury? ☐ X-ray ☐ MRI ☐ CT scan ☐ Ultrasound ☐ Bone Scan