



Basketball/Football History Form

Date: _____ Patient #: _____

Name: _____ Age: _____ Date: _____

1. When did you first notice symptoms? _____

Re-injury: ___Y / ___ N

2. Describe symptoms (area/right side/left side): _____

3. Type of pain: ___Dull ___Throbbing ___Intermittent ___Sore ___Sharp ___Constant ___Burning ___Bruised

4. Onset: ___ Gradual ___ Sudden

5. What was the onset of your symptoms related to:

___ Don't know ___ Change in shoes: from _____ to _____

___ Other _____

6. When do your symptoms occur: _____

7. What helps relieve your symptoms: _____

8 What increases your symptoms: _____

9. Have you been treated for this condition previously: ___Y / ___ N When: _____

By whom: _____ What was the treatment: _____

10. Have you had any other issues related to your sport: ___Y / ___ N What: _____

When: _____ Treatment: _____

By whom: _____

11. What effects do your symptoms have on your training: _____

___ Pain during workout but able to train ___ Unable to train ___ Training compromised by pain

___ Other _____

12. Have you had any surgery within the last two years: ___Y / ___ N

If yes, what type of surgery and when: _____

13. Please check all that apply:

- Shoulder: _____ Sprain _____ Dislocation _____ Separation _____ Fracture When and which side: _____
Elbow: _____ Sprain _____ Dislocation _____ Separation _____ Fracture When and which side: _____
Hand: _____ Sprain _____ Dislocation _____ Separation _____ Fracture When and which side: _____
Wrist: _____ Sprain _____ Dislocation _____ Separation _____ Fracture When and which side: _____
Fingers: _____ Sprain _____ Dislocation _____ Separation _____ Fracture When and which side: _____
Knee: _____ Sprain _____ Dislocation _____ Separation _____ Fracture When and which side: _____
Ankle: _____ Sprain _____ Dislocation _____ Separation _____ Fracture When and which side: _____
Back: _____ Sprain _____ Dislocation _____ Fracture When and which side: _____

14. Type of athlete: _____ Fitness _____ High School _____ Recreation
_____ Club _____ Professional _____ College

15. Frequency of training: _____ Daily _____ Weekly _____ Monthly

16. How long have you been participating in your sport: _____

17. Do you wear orthotics or other corrective devices: _____
How long have you worn them: _____ What effect do they have: _____
Who prescribed them: _____

18. Have you required Athletic taping/wrapping: _____ Y / _____ N
If so, where: _____

19. Do you stretch regularly: _____ Y / _____ N _____ Before playing _____ After playing _____ How long

20. Female athlete – Normal menstrual cycles: _____ Y / _____ N

21. Athletic affiliation/Club/School: _____
Coach's Name: _____ Phone: _____ email: _____

22. What other sports or cross training do you participate in on a regular basis: _____
