HMC Antoniushove

Sports Medicine Injury form

Name: _____

Date of birth: _____

Occupation: _____

How many hours per week: _____ **% sit / stand**

Height: _____ / **Weight:** _____

Date of visit: _____

Referred by: _____

Location injury ☐ **right** ☐ **left** ☐ **other (specify)** _____

☐ head	☐ upper arm	☐ wrist	☐ chest	☐ abdomen	☐ lower leg	☐ foot
☐ neck	☐ elbow	☐ hand	☐ hip / pelvis	☐ back	☐ knee	☐ toes
☐ shoulder	☐ fore arm	☐ fingers	☐ groin	☐ thigh	☐ ankle	☐ achilles tendon

Surgery / Illness / injury

Year	Diagnose	Name of doctor / hospital
1. _____	_____	_____
2. _____	_____	_____

Medication

	Dose	Dietary supplements
1. _____	_____	_____
2. _____	_____	_____

Sport

	No. of years	times/week	how long?	level	name of the club
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

Duration of the problem _____**weeks / months / years** **How long did you have to reduce / stop sports?** _____**weeks / months / years**

How did the injury occur?

_____

_____

What have you done to treat it yourself?

_____

_____

Have other doctors / physiotherapists already examined your injury?

_____

_____

Which treatment did you receive / which doctor?

_____

_____

Other

_____

_____

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