

Sports Medicine Intake Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Emergency Contact

Contact Name

Contact Phone

Relationship

Insurance Information

Provider Name

Policy Number

Current Injury/Concern

Describe your current injury or concern

Date of Injury/Onset

Side of Body

What aggravates your symptoms?

What eases your symptoms?

Activity & Medical History

Sports/Activities You Participate In

List any ongoing medical conditions

Past injuries or surgeries (with dates, if possible)

Allergies (including medications)

Current Medications