New Patient Information

THE SPORTS CLINIC

Is this a result of a car accident? ☐ Yes ☐ No

IF YES: Claim # _____ Date of Accident: _____

Extended/Private Insurance Company: _____

Auto Insurance Company: _____

Adjuster Name: _____

Adjuster Phone: _____ Adjuster Fax: _____

MEDICAL HISTORY

Identify any cardiovascular issues

Blood Pressure (high/low)	☐ Yes	☐ No
Cholesterol (high/low)	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
History of heart disease or stroke	☐ Yes	☐ No
Pacemaker or similar device	☐ Yes	☐ No

Identify any pulmonary issues

Do you smoke?	☐ Yes	☐ No
If Yes, for how long? _____		
Asthma	☐ Yes	☐ No
History of bronchitis or pneumonia	☐ Yes	☐ No

Identify any other medical issues

Bleeding disorders (i.e. hemophilia, sickle cell, etc.)	☐ Yes	☐ No
Diabetes – Type I or Type II	☐ Yes	☐ No
Bowel or bladder problems	☐ Yes	☐ No
History of cancer	☐ Yes	☐ No
Currently pregnant or possibly pregnant	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Difficulty Speaking	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No
Suddenly falling (i.e. legs giving out)	☐ Yes	☐ No

Previous surgeries … if yes, please list ☐ Yes ☐ No

_____

_____

_____

List previous injuries and when sustained:

_____

_____

_____

List any medication you are currently taking:

_____

_____

_____

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