2019-2020

NEW PLAYER’S PACKET

INFORMATION AND INSTRUCTIONS
FOR ALL NEW STUDENT-ATHLETES
WHO DID NOT ATTEND ATHLETIC PHYSICALS

GENERAL INFORMATION:

- Please read these instructions carefully. Failure to follow them will prevent you from participating with your team.
- All forms must be printed and submitted single-sided only.
- The purpose of the Athletic Physical is to: provide the certified athletic trainers with an accurate health history; introduce you to the healthcare providers you will be working with; ensure that any current health conditions you have are being managed appropriately and in compliance with NCAA regulations; to identify any characteristics that may put you at increased risk for future injury or disease; and to educate you regarding health risks and at-risk behaviors.
- These forms are the foundation of your medical records. They are completely confidential. The information on the forms cannot and will not be discussed for purposes beyond treating you and processing claims for individual injuries without express permission from you.
- Once you and your physician complete the New Player’s Packet, bring it directly to the Athletic Training Room in the Danzi Athletic Center. When the packet is acceptable, you will be scheduled for Baseline Concussion Testing and an Orthopedic Screening with a staff certified athletic trainer. After these tests are completed, you will be medically cleared for activity. Please realize that the appointments for these tests are limited and are scheduled on a first-come, first-serve basis. Therefore, it is recommended that you do not wait until the day before your first scheduled activity to submit your packet.
- All of these forms must be COMPLETE, VALID, SIGNED AND SUBMITTED TO LISA KOMNIK, HEAD CERTIFIED ATHLETIC TRAINER BEFORE YOU CAN BEGIN PRACTICE!
THE FORMS AND INSTRUCTIONS:

1. **Athletic Physical Form**
   There are six sections on this form. You must complete the Athlete Information (both pages), Emergency Information and Insurance Information sections. Your physician will complete the Physical Exam and Overall Physical Exam Results sections.

   The Orthopedic Exam section only needs to be completed if you are currently undergoing treatment or recovering from an injury. It should be completed by the treating orthopedist.

   Please make sure that you sign the bottom of the second page. Only when all sections are complete and the form is signed, dated and stamped will the Athletic Physical Form be considered complete and valid. **Please note that all sections MUST be completed. Blanks and “n/a” are not acceptable.**

   All physicals must be completed after **July 1, 2019**.

2. **Copy of Insurance Card(s)**
   St. Joseph’s College requires all students to have primary health insurance. You must provide a copy of the front and back of your insurance card(s). If you have coverage through more than one person, copies of each card must be provided. You are required to update this form with any changes throughout the year. Please contact the Office of the Vice President of Student Life at 631.687.4595 for additional information regarding health insurance coverage requirements.

3. **Athletic General Medical History Form**
   All student-athletes at St. Joseph’s College – Long Island complete this document once during their career. It is a YES/NO/EXPLAIN survey that summarizes your overall medical past. This form gives us vital information about each individual we will work with and be responsible for. We encourage you to consult with your parent or guardian when completing this form in order to provide the most accurate information.

4. **Orthopedic Medical History Form**
   All student-athletes at St. Joseph’s College – Long Island complete this document once during their career. It is a YES/NO/EXPLAIN survey that summarizes your orthopedic medical past. This form will serve as the foundation for the Orthopedic Screening you will receive.

5. **Medication Declaration Form**
   This form is where you should list ALL medications you use (over-the-counter and prescription, including birth control, inhalers and/or Epi-pens) as well as any supplements you are taking. A certified athletic trainer will be available to answer any specific questions you may have. This form meets the NCAA requirements for medication documentation and will be used if you have a positive drug test. You must read and sign the NCAA Nutritional/Dietary supplements warning at the top of this page. You are required to update this form with any changes throughout the year.

   We ask that you provide the Sports Medicine Department with any rescue device you use (inhaler and/or epinephrine injector). Please bring an extra device with you when you submit your Player Packet. This device will be placed in your team’s medical kit for use in case of emergency.
THE FORMS AND INSTRUCTIONS CONTINUED:

6. Acknowledge/Waiver/Release Form
   By signing this form, you are acknowledging the inherent risk of sport and voluntarily assuming that risk; you are agreeing to participate in your healthcare; you understand the limitations of the secondary insurance accident policy; and you are allowing the Sports Medicine Department at St. Joseph’s College to treat you.

If you are under 18 years of age, a parent or guardian must co-sign the form.

7. Health Insurance Portability and Accountability Act (HIPAA) Form
   This form allows the Sports Medicine Department to access and share medical information about you with treating and billing entities for the purpose of your care and bill payment only. This form also ensures the confidentiality of all of your medical records at St. Joseph’s College.

If you are under 18 years of age, a parent or guardian must co-sign the form.

8. Sickle Cell Trait status verification
   The NCAA requires that we verify and document each athlete’s Sickle Cell Trait status. Information about Sickle Cell Disease, Anemia and Trait can be found on our web page (www.sjcgoldeneagles.com/Sports_Medicine). No form of Sickle Cell Disease, Anemia or Trait will exclude an athlete from intercollegiate athletics at St. Joseph’s College.

   You may already have acceptable documentation of your Sickle Cell Trait status as New York State mandates testing at birth. If you are able to locate this documentation, you will need to provide it. Proper documentation is based on the results of either a Hemoglobin Solubility test or Hemoglobin Electrophoresis test. A total hemoglobin test is NOT sufficient. The results must be a lab report or a letter from the physician who ordered the test, on the physician’s letterhead, dated and with his or her original signature. Stamps and faxes will NOT be accepted.

   If you have not been tested or cannot locate proper documentation (as listed above), you will have to report to your primary care physician and request a Sickle Cell Trait screening. The test must be either a Hemoglobin Solubility test or Hemoglobin Electrophoresis test. A total hemoglobin test will not be sufficient. You will have to get the test done and then submit a copy of the lab report. Please realize that this option may take time and that no athlete will be permitted to practice or compete until Sickle Cell Trait status documentation is on file.

QUESTIONS:

Any questions can be directed to the Danzi Center Athletic Training Room. Our telephone number is 631.687.1454, the fax number is 631.687.1453.
# 2019-20 ST. JOSEPH'S COLLEGE – LONG ISLAND ATHLETIC PHYSICAL FORM

**ATHLETE INFORMATION:** The student-athlete should complete this section before the exam.

Name: ___________________________ M F DOB: ___________________________

Street Address: __________________ City, State, Zip: __________________

Home phone: ( ) ___________ Cell phone: ( ) ___________ Email: __________________

Sport(s): ___________________________ Position(s): ___________________________ Year in school: 1 2 3 4 5

Medications: ___________________________ Allergies: ___________________________ Glasses / Contacts?

**MEDICAL HISTORY UPDATE:**

Have you sustained any injury/illness since last exam, including a head injury, infection, etc? Yes ___ No ___

If yes, please explain: ______________________________________________________

Are you currently being treated (ex MD, PT, chiropractor, etc.)? Yes ___ No ___ Reason ___________ ___________

Is there anything you would like to discuss at this visit? ________________________________________________________________________________

**PHYSICAL EXAM:** FORM WILL NOT BE ACCEPTED WITH ANY BLANKS!

**ORTHOPEDIC EXAM**

PMHX: ___________________________ Reason for exam: ___________________________

Findings: ___________________________ Recommendations: ___________________________

Signature of Physician: ___________________________ Date of exam: ___________________

**GENERAL MEDICAL EXAM**

PMHX: ___________________________

Ht: ___________ in Brachial pulse/min: ___________ R) eye 20/20 corrected? BP: ___________

Wt: ___________ lbs Femoral pulse/min: ___________ L) eye 20/20 corrected? BP Arm: ___________

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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</table>

**MUSCULOSKELETAL**

- Neck
- Back/Spine/Scoliosis
- Shoulder/Upper arm
- Elbow/Forearm
- Wrist/Hand/Fingers
- Hip/Thigh
- Knee/Lower leg
- Ankle
- Foot/Toes
- Neurological

**MEDICAL**

- Appearance
- Eyes/Ears/Nose/Throat
- Hearing
- Neck/Teeth
- Lymph Nodes
- Heart
- Lungs/Respiratory
- Abdomen/Hernia
- Skin/Scalp

**OVERALL PHYSICAL EXAM RESULTS:** Based on all available information, please check A, B, or C:

A. Individual is cleared for (choose one): _______ all sports OR _______ non-contact sports only

B. Advised to consult physician for: ___________________________

C. Deferred due to: ___________________________

Signature of Physician: ___________________________ Date of exam: ___________

Office stamp with telephone number:
ATHLETE INFORMATION:
Name:_____________________________ M F DOB:_________________
Street address:____________________ City, State, Zip:____________________
Home phone:(____)_________________ Cell phone:(____)_________________ Email:____________________
Sport(s):_________________________ Position(s):____________________ Year in school: 1 2 3 4 5
Medications:_______________________ Allergies:_______________________ Glasses / contacts?

EMERGENCY INFORMATION:
Notify in case of emergency:______________________________
Relationship:____________________________________
Contact number(s) with area code:_____________________

INSURANCE INFORMATION:

PRIMARY INSURANCE – complete with the policy holder’s information
Policy Holder’s Name:________________ Relationship to athlete:________ DOB:_____
Address:____________________________ Telephone:____________________
Employer:____________________________ Telephone:____________________
Insurance Company:__________________ Policy/Group #:________________
Insurance Company Address:________________________________________

SECONDARY INSURANCE (if applicable) – complete with the policy holder’s information
Policy Holder’s Name:________________ Relationship to athlete:________ DOB:_____
Address:____________________________ Telephone:____________________
Employer:____________________________ Telephone:____________________
Insurance Company:__________________ Policy/Group #:________________
Insurance Company Address:________________________________________

You must provide a photocopy of the front and reverse sides of all insurance cards.

I hereby certify that the foregoing answers I have designated to the stated questions are true, complete and correct to the best of my knowledge.

Signature:_________________________ Date:______________
ST. JOSEPH’S COLLEGE – LONG ISLAND MEDICATION DECLARATION FORM

It is your responsibility to update this information as your medications and supplement use changes.

**NCAA Nutritional/Dietary Supplements Warning:**

Before consuming any nutritional/dietary supplement product, review the product with a certified athletic trainer!

- Dietary supplements are not well regulated and may cause a positive drug test result.
- Student-athletes have tested positive and lost their eligibility using dietary supplements.
- Many dietary supplements are contaminated with banned drugs not listed on the label.
- **Any product containing a dietary supplement ingredient is taken at your own risk.**

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

| PHYSICIAN NAME: ___________________________ | TELEPHONE: ___________________________ |
| MEDICATION NAME: ___________________________ | DOSAGE: ___________________________ |
| INSTRUCTIONS: ___________________________ | DATE FILLED: __________ | REFILLS: ________ |
| PHARMACY: ___________________________ | TELEPHONE: ___________________________ | RX NO.: ________ |

| PHYSICIAN NAME: ___________________________ | TELEPHONE: ___________________________ |
| MEDICATION NAME: ___________________________ | DOSAGE: ___________________________ |
| INSTRUCTIONS: ___________________________ | DATE FILLED: __________ | REFILLS: ________ |
| PHARMACY: ___________________________ | TELEPHONE: ___________________________ | RX NO.: ________ |

| PHYSICIAN NAME: ___________________________ | TELEPHONE: ___________________________ |
| MEDICATION NAME: ___________________________ | DOSAGE: ___________________________ |
| INSTRUCTIONS: ___________________________ | DATE FILLED: __________ | REFILLS: ________ |
| PHARMACY: ___________________________ | TELEPHONE: ___________________________ | RX NO.: ________ |

| PHYSICIAN NAME: ___________________________ | TELEPHONE: ___________________________ |
| MEDICATION NAME: ___________________________ | DOSAGE: ___________________________ |
| INSTRUCTIONS: ___________________________ | DATE FILLED: __________ | REFILLS: ________ |
| PHARMACY: ___________________________ | TELEPHONE: ___________________________ | RX NO.: ________ |

**SUPPLEMENT NAME(S):** ____________________________________________

| AMOUNT USED PER DAY: ___________________________ | IF TAKEN WITH WATER, HOW MUCH: ________ |
| DURATION OF USE: ___________________________ | WHERE PURCHASED: ___________________________ |

Received by: ___________________________ Date: ___________ Rev July 19
RISK ACKNOWLEDGEMENT

I am aware that playing or practicing in any sport, athletic event or activity can be a dangerous activity involving many risks or injuries. I understand that the dangers and risks of playing or practicing in the sport(s) listed below include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all internal organs, bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system and serious injury or impairment to other aspects of my body, general health and well-being.

This includes, but is not limited to illness; infection; adverse reactions to medications; or allergies; signs and symptoms of a head injury or concussion.

PARTICIPANT RESPONSIBILITY

I, _________________________ (print name), acknowledge that I have to be an active participant in my own healthcare. I have the direct responsibility for reporting all of my injuries and illnesses to a St. Joseph’s College Certified Athletic Trainer. I acknowledge and understand that it is essential for my general health and well-being that I not participate in the below sport(s) unless I am in good health and physical condition. I have advised a St. Joseph’s College Certified Athletic Trainer of any limitations on my participation for any medical reasons. I further acknowledge and understand that it is my responsibility to continue to notify a St. Joseph’s College Certified Athletic Trainer of any new injury or illness that affects my general condition regardless of how the injury was sustained, as well as any new limitations on my medical condition through my enrollment or participation in sports or athletic activities at St. Joseph’s College.

I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to a St. Joseph’s College Certified Athletic Trainer.

STATEMENT OF SECONDARY INSURANCE LIMITATIONS

I certify that I have health insurance which affords coverage for sickness and accident expenses. In the event of an athletically related injury that engages the college’s secondary coverage, I am responsible for all costs that exceed usual and customary charges and/or the duration of plan coverage.

WAIVER

In consideration of St. Joseph’s College permitting me to practice, play, or tryout for ____________________________ (sport or sports), and to engage in all activities related to the team, including practicing, playing and travel, I hereby voluntarily assume all risks associated with the participation and agree to exonerate and save harmless St. Joseph’s College, their agents, servants, employees, the St. Joseph’s College athletic staff, the physicians, Certified Athletic Trainers, and other practitioners of the healing arts treating me, from any and all liability, claims, causes of action or demands of any kinds and nature whatsoever which may arise by or in connection with my participation in any activities related to the ____________________________ team(s).

The terms hereof shall serve as a release and assumption of risks for my heirs, executor, administrator, assignees and all members of my family.

CONSENT TO TREAT

I, _________________________ (print name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team/school/family physician, licensed physical therapists, certified athletic trainers and other practitioners of the healing arts. Under the direction of a certified athletic trainer, this also may include college/university student athletic trainers, and high school student athletic trainers.
ST. JOSEPH’S COLLEGE – LONG ISLAND

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize St. Joseph’s College to provide information related to my care to the family/school/team physician, coaches, athletic directors, EMS personnel and other qualified medical personnel as needed for them to provide consultation, treatment, and establish a plan of care.

I give authorization to St. Joseph’s College to access medical or other information stored in various forms related to treatment or services provided to me in connection with my care, healthcare operations or payment for treatment and services. I also authorize information related to my care to be provided to my family/school/team physician and such persons as necessary for them to provide consultation, treatment and/or services to me. I understand that this authorization is in effect for one year from the date below.

I understand that health record(s) will not be released without my signature below. I understand that I have the right to revoke this authorization at any time by sending in a written request. My decision to revoke does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke authorization.

______________________________  ___________________________  ____________
Printed name                     Signature                        Date

If student is under 18, printed name of parent  ___________________________  ___________________________
Signature of parent                Date
### ST. JOSEPH’S COLLEGE – LONG ISLAND ATHLETIC MEDICAL HISTORY FORM

**We encourage you to consult with a parent or guardian when completing this form. Explain all “Yes” answers below.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Have you had a medical illness or injury since your last check up or sports physical?</td>
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<tr>
<td>2. Do you have an ongoing or chronic illness/injury that requires periodic medical supervision, medication or other therapy? (i.e. cancer, diabetes, seizure, ADHD, or disability)?</td>
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<td>3. Has a doctor ever excluded you from activity for 2 or more weeks?</td>
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<td>4. Do you have only one of a paired organ (eye, kidney, testicle, ovary, etc.)?</td>
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<td>5. Are you currently taking any prescription or over-the-counter medication, pills, or an inhaler? (See Medication Declaration form)</td>
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<tr>
<td>6. Have you ever or do you currently take any supplements or vitamins to help you gain or lose weight or improve your performance? (See Medication Declaration form)</td>
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<tr>
<td>7. Do you want to weigh more ___ or less__? Have you gained or lost more than 10 pounds this year? Have you ever sought treatment for an eating disorder?</td>
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<tr>
<td>8. Do you have any allergies to medications? Do you have allergies to bites or stings? Do you have any food allergies/intolerances? Are you treated for seasonal allergies? Do you have an epinephrine injector?</td>
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<tr>
<td>9. Have you ever: • Passed out during or after exercise? • Been dizzy during or after exercise? • Been overly fatigued during exercise? • Had chest pain or discomfort during or after exercise? • Had racing of your heart or skipped heartbeats? • Been told you have a heart murmur? • Had a severe viral infection (myocarditis, mononucleosis)? • Had an EKG? Echocardiogram? Has a physician ever denied or restricted your participation in sports for any heart problem?</td>
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<tr>
<td>10. Has any family member or relative died of heart problems or of sudden death &lt; age 50? Has any family member or yourself been diagnosed with Marfan syndrome, hypertrophic or dilated cardiomyopathy, long-QT syndrome or any arrhythmias? Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Does anyone in your family have high blood pressure or cholesterol? Have you ever been told you have high blood pressure or cholesterol?</td>
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<tr>
<td>11. Have you ever had a head injury or concussion? Have you ever had seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, or pinched nerve?</td>
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<tr>
<td>12. Do you cough, wheeze, or have trouble breathing during or after activity? Have you been diagnosed or treated for asthma?</td>
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<td>13. Does anyone in your family have Sickel Cell Trait, Disease or Anemia? Do you have any other blood disorder?</td>
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<td>14. Have you ever become ill from exercising in the heat (ex: heat cramps, exhaustion)? Have you ever become ill from exercising in the cold (ex: frostbite)?</td>
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<td>15. Do you have any skin disorders?</td>
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<td>16. Do you use any special protective or corrective equipment/devices (brace, orthotics, hearing aid)?</td>
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<td>17. Do you have any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear when participating in athletics?</td>
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<td>18. Do you wear braces, retainer, or other oral implants?</td>
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<td>19. Have you ever or do you use tobacco, in any form?</td>
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<td>20. Are you a vegetarian or vegan? Do you have an alternative eating style (paleo, keto, gluten free, whole 30, etc.)?</td>
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<td>21. Do you generally feel stressed out or anxious? FEMALES ONLY</td>
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<td>22. Age at your first menstrual period:</td>
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<td>23. Date of your most recent period:</td>
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<td>24. How many days do you usually have from the start of one period to the start of another?</td>
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<td>25. How many periods have you had in the last year?</td>
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<td>26. Name of OB/GYN MD or practice: MALES ONLY</td>
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<tr>
<td>27. Have you ever had a hernia? If so, was the hernia repaired?</td>
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<tr>
<td>28. Have you ever been diagnosed with testicular torsion? Was the torsion reduced?</td>
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</table>

**EXPLAIN ALL YES ANSWERS HERE:**

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All statements and answers on this form are true and complete. I have no abnormality, limitation or restriction not mentioned on this form. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur. I understand that all information is confidential.

**Signature of athlete:** ____________________________ **Date:** ________________ **Rev June 19**
ST. JOSEPH’S COLLEGE-LI ORTHOPEDIC MEDICAL HISTORY FORM

For each section, please circle either YES or NO for question 1. If you answer NO, proceed to the next section. If you answer YES, please complete the entire section.

I. FRACTURES
1. Have you ever broken a bone? YES NO
   If NO, move on to section II.
   If YES, please indicate location and date from list below:

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Date(s)</th>
<th>Body Part</th>
<th>Right</th>
<th>Left</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skull</td>
<td></td>
<td>Collar Bone</td>
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<tr>
<td>Nose</td>
<td></td>
<td>Upper Arm</td>
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<tr>
<td>Face</td>
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<td>Forearm</td>
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<td>Jaw</td>
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<td>Spine</td>
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<td>Hand</td>
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<td>Pelvis</td>
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<td>Thigh</td>
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<td>Ribs</td>
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<td>Lower Leg</td>
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<td>Foot</td>
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<td>Toes</td>
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</table>

2. Did the fracture require surgery? YES NO
   If YES, please indicate type of surgery, date, physician and office telephone number:

3. Did you perform physical therapy? YES NO
   If YES, please list name and telephone number of the clinic:
   If YES, did you complete treatment? YES NO
   Do you have any lingering problems or concerns related to this injury? YES NO
   If YES, what are they?

II. DISLOCATIONS
1. Have you ever dislocated a joint? YES NO
   If NO, move on to section III.
   If YES, please indicate location and date below:

<table>
<thead>
<tr>
<th>Body Part</th>
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<th># of Times</th>
<th>Date(s)</th>
<th>Body Part</th>
<th>Right</th>
<th>Left</th>
<th># of Times</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
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<td></td>
<td>Hip</td>
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<tr>
<td>AC Joint</td>
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<td></td>
<td></td>
<td>Knee</td>
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<tr>
<td>Elbow</td>
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<td></td>
<td>Knee Cap</td>
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<td>Wrist</td>
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<td>Ankle</td>
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<tr>
<td>Fingers</td>
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<td>Toes</td>
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</tbody>
</table>

2. Did the dislocation require surgery? YES NO
   If YES, please indicate type of surgery, date, physician and office telephone number:

3. Did you perform physical therapy? YES NO
   If YES, please list name and telephone number of the clinic:
   If YES, did you complete treatment? YES NO
   Do you have any lingering problems or concerns related to this injury? YES NO
   If YES, what are they?
III. UPPER EXTREMITY INJURY
1. Have you ever sustained an upper extremity injury other than a fracture or dislocation? **YES** **NO**
   - If **NO**, move on to section IV.
   - If **YES**, please indicate and date below:

<table>
<thead>
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<td>Chest</td>
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<td>Elbow</td>
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<td>Scapula</td>
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<td>Wrist</td>
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<td>Upper Arm</td>
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<td>Hand</td>
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<td>Forearm</td>
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<td>Fingers</td>
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2. Please describe to the best of your knowledge the injury type(s).

____________________________________________________________________________________

3. Did the injury require surgery? **YES** **NO**
   - If **YES**, please indicate type of surgery, date, physician and office telephone number.

____________________________________________________________________________________

4. Did you perform physical therapy? **YES** **NO**
   - If **YES**, please list name and telephone number of the clinic:
   - If **YES**, did you complete treatment? **YES** **NO**
   - Do you have any lingering problems or concerns related to this injury? **YES** **NO**
   - If **YES**, what are they?

____________________________________________________________________________________

IV. LOWER EXTREMITY INJURY
1. Have you ever sustained a lower extremity injury other than a fracture or dislocation? **YES** **NO**
   - If **NO**, move on to section V.
   - If **YES**, please indicate and date below:

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<tbody>
<tr>
<td>Hip</td>
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<td>Thigh</td>
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<td>Knee</td>
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<td>Knee/Knee Cap</td>
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<td>Ankle</td>
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<td>Lower Leg</td>
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<td>Foot</td>
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<td>Toes</td>
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</table>

2. Please describe to the best of your knowledge the injury type(s).

____________________________________________________________________________________

3. Did the injury require surgery? **YES** **NO**
   - If **YES**, please indicate type of surgery, date, physician and office telephone number.

____________________________________________________________________________________

4. Did you perform physical therapy? **YES** **NO**
   - If **YES**, please list name and telephone number of the clinic:
   - If **YES**, did you complete treatment? **YES** **NO**
   - Do you have any lingering problems or concerns related to this injury? **YES** **NO**
   - If **YES**, what are they?

____________________________________________________________________________________
ST. JOSEPH’S COLLEGE-LI ORTHOPEDIC MEDICAL HISTORY FORM

V. HEAD, NECK, SPINE OR PELVIS INJURY

1. Have you ever sustained and injury to your head, neck, spine, or pelvis?  
   YES  NO  
   This includes any type of disc problem or scoliosis.  
   If NO, move on to section VI.  
   If YES, please indicate and date below:

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<th>Body Part</th>
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<tbody>
<tr>
<td>Head</td>
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<tr>
<td>Concussion</td>
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<td>Neck</td>
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<td>Spine</td>
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<tr>
<td>Pelvis</td>
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2. Please describe to the best of your knowledge the injury type(s).

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

3. Did the injury require diagnostic testing (ex: MRI, CT, EMG, etc.)?  
   YES  NO  
   If YES, please indicate which test(s) were performed, when and the provider:

__________________________________________________________________________

4. Did the injury require surgery?  
   YES  NO  
   If YES, please indicate type of surgery, date, physician and office telephone number.

__________________________________________________________________________
__________________________________________________________________________
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5. Did you perform physical therapy?  
   YES  NO  
   If YES, please list name and telephone number of the clinic:
   If YES, did you complete treatment?  YES  NO  
   Do you have any lingering problems or concerns related to this injury?  YES  NO  
   If YES, what are they?

VI. TREATMENT BY ALLIED HEALTH CARE PROVIDERS

1. Have you ever received treatment from a podiatrist (foot doctor)?  
   YES  NO  
   If YES, for what reason?  
   If YES, please list name and telephone number of the provider:
   Were you given orthotics or other inserts?  
   Do you wear the orthotics for (please circle all that apply): daily activity, training, competition?  
   How old are they?  
   Do they help?  
   YES  NO  
   Are you currently being treated by this or any other podiatrist?  
   YES  NO

2. Have you ever received treatment from a chiropractor?  
   YES  NO  
   If YES, for what reason?  
   If YES, please list name and telephone number of the provider:
   Are you currently being treated by this or any other chiropractor?  
   YES  NO

3. Have you ever or are you currently being treated by any other health care practitioners?  
   YES  NO  
   If YES, for what reason?  
   If YES, please list name and telephone number of the provider:

VII. OTHER CONCERNS

Please list any other orthopedic concerns you may have or issues you would like to discuss.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Revised July 19